17:48-6 et. al

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2017 **CHAPTER:** 361

NJSA: 17:48-6 et. al (Extends health benefits coverage of a newborn infant.)

BILL NO: A2665 (Substituted for S837)

SPONSOR(S) Lampitt and others

DATE INTRODUCED: 2/8/2016

COMMITTEE: **ASSEMBLY:** Financial Institutions & Insurance

SENATE: Commerce
Budget & Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 1/8/2018

SENATE: 1/5/2018

DATE OF APPROVAL: 1/16/2018

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First Reprint enacted) Yes

A2665

SPONSOR'S STATEMENT: (Begins on page 17 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes Finan. Institutions & Insurance

SENATE: Yes Commerce
Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes 6/20/2016
12/18/2017

S837

SPONSOR'S STATEMENT: (Begins on page 17 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Commerce
Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

(continued)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

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RH/CL

P.L. 2017, CHAPTER 361, ***approved January 16, 2018***
Assembly, No. 2665 ***(First Reprint)***

AN ACT extending the health benefits coverage of a newborn infant and amending various parts of the statutory law.

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

1. Section 6 of P.L.1938, c.366 (C.17:48-6) is amended to read as follows:

6. Every individual contract made by a corporation subject to the provisions of this chapter to furnish services to a subscriber shall provide for the furnishing of services for a period of 12 months, and no contract shall be made providing for the inception of such services at a date later than 1 year after the actual date of the making of such contract. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been at least 30 days' prior written notice of termination by either the subscriber or the corporation. In the absence of fraud or material misrepresentation in the application for a contract or for reinstatement, no contract with an individual subscriber shall be terminated by the corporation unless all contracts of the same type, in the same group or covering the same classification of persons are terminated under the same conditions.

No contract between any such corporation and a subscriber shall entitle more than one person to services, except that a contract issued as a family contract may provide that services will be furnished to a husband and wife, or husband, wife and their dependent child or children, or the subscriber and his (or her) dependent child or children. Adult dependent(s) of a subscriber may also be included for coverage under the contract of such subscriber.

Whenever, pursuant to the provisions of a subscription certificate or group contract issued by a corporation, the former spouse of a named subscriber under such a certificate or contract is no longer entitled to coverage as an eligible dependent by reason of divorce, separate coverage for such former spouse shall be made available by the corporation on an individual non-group basis under the following conditions:

(a) Application for such non-group coverage shall be made to the corporation by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(b) No new evidence of insurability shall be required in connection with the application for such non-group coverage but any health

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SCM committee amendments adopted December 4, 2017.

exception, limitation or exclusion applicable to said former spouse under the prior coverage may, at the option of the corporation, be carried over to the new non-group coverage.

(c) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(d) The benefits provided under the non-group coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the corporation to new non-group applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within [31] [1][61] 60[1] days after the date of birth in order to have the coverage continue beyond such [31] [1][61] 60[1]-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] [1][61] 60[1] days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a hospital service corporation to insure as a covered dependent any child with an intellectual disability or physically handicapped child of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude

1 such child with an intellectual disability or physically handicapped
2 child from coverage.
3 Every individual contract entered into by any such corporation
4 with any subscriber thereto shall be in writing and a certificate stating
5 the terms and conditions thereof shall be furnished to the subscriber to
6 be kept by him. No such certificate form shall be made, issued or
7 delivered in this State unless it contains the following provisions:
8 (a) A statement of the contract rate, or amount payable to the
9 corporation by or on behalf of the subscriber for the original quarter-
10 annual period of coverage and of the time or times at which, and the
11 manner in which, such amount is to be paid; and a provision requiring
12 30 days' written notice to the subscriber before any change in the
13 contract, including a change in the amount of subscription rate, shall
14 take effect;
15 (b) A statement of the nature of the services to be furnished and
16 the period during which they will be furnished; and if there are any
17 services to be excepted, a detailed statement of such exceptions printed
18 as hereinafter specified;
19 (c) A statement of the terms and conditions, if any, upon which the
20 contract may be amended on approval of the commissioner or canceled
21 or otherwise terminated at the option of either party. Any notice to the
22 subscriber shall be effective if sent by mail to the subscriber's address
23 as shown at the time on the plan's record, except that, in the case of
24 persons for whom payment of the contract is made through a remitting
25 agent, any such notice to the subscriber shall also be effective if a
26 personalized notice is sent to the remitting agent for delivery to the
27 subscriber, in which case it shall be the responsibility of the remitting
28 agent to make such delivery. The notice to the subscriber as herein
29 required shall be sent at least 30 days before the amendment,
30 cancellation or termination of the contract takes effect. Any rider or
31 endorsement accompanying such notice, and amending the rates or
32 other provisions of the contract, shall be deemed to be a part of the
33 contract as of the effective date of such rider or endorsement;
34 (d) A statement that the contract includes the endorsements
35 thereon and attached papers, if any, and contains the entire contract for
36 services;
37 (e) A statement that no statement by the subscriber in his
38 application for a contract shall avoid the contract or be used in any
39 legal proceeding thereunder, unless such application or an exact copy
40 thereof is included in or attached to such contract, and that no agent or
41 representative of such corporation, other than an officer or officers
42 designated therein, is authorized to change the contract or waive any of
43 its provisions;
44 (f) A statement that if the subscriber defaults in making any
45 payment under the contract, the subsequent acceptance of a payment
46 by the corporation or by one of its duly authorized agents shall
47 reinstate the contract, but with respect to sickness and injury may

cover such sickness as may be first manifested more than 10 days after the date of such acceptance;

(g) A statement of the period of grace which will be allowed the subscriber for making any payment due under the contract. Such period shall be not less than 10 days.

In every such contract made, issued or delivered in this State:

(a) All printed portions shall be plainly printed in type of which the face is not smaller than 10 point;

(b) There shall be a brief description of the contract on its first page and on its filing back in type of which the face is not smaller than 14 point;

(c) The exceptions of the contract shall appear with the same prominence as the benefits to which they apply; and

(d) If the contract contains any provision purporting to make any portion of the articles, constitution or bylaws of the corporation a part of the contract, such portion shall be set forth in full.

(cf: P.L.2010, c.50, s.3)

2. Section 2 of P.L.1964, c.104 (C.17:48-6.1) is amended to read as follows:

2. A hospital service corporation may issue to a policyholder a group contract, covering at least two employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions, or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within ⟦31⟧ [1]⟦61⟧ 60[1] days after the date of birth in order to have the coverage continue beyond such ⟦31⟧ [1]⟦61⟧ 60[1]day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] [1][61] 60[1] days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such conditions, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a hospital service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall provide that, subject to payment of the appropriate premium, such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the individual proprietor or partners of an individual proprietorship or a partnership. The contract may provide that the term "employees" shall include retired employees. A contract issued to trustees may provide that the term "employees" shall include

1 the trustees or their employees, or both, if their duties are principally
2 connected with such trusteeship. A contract issued to the trustees of a
3 fund established by the members of an association of employers may
4 provide that the term "employees" shall include the employees of the
5 association.
6 (cf: P.L.2010, c.50, s.4)
7
8 3. Section 5 of P.L.1940, c.74 (C.17:48A-5) is amended to read as
9 follows:
10 5. Every individual contract made by any corporation subject to
11 the provisions of this chapter to provide payment for medical services
12 shall provide for the payment of medical services for a period of 12
13 months from the date of issue of the subscription certificate. Any such
14 contract may provide that it shall be automatically renewed from year
15 to year unless there shall have been 1 month's prior written notice of
16 termination by either the subscriber or the corporation. In the absence
17 of fraud or material misrepresentation in the application for contract or
18 for reinstatement, no contract with an individual subscriber shall be
19 terminated by the corporation unless all contracts of the same type, in
20 the same group or covering the same classification of persons are
21 terminated under the same conditions. No contract between such
22 corporation and subscriber shall allow for the payment for medical
23 services for more than one person, except that a family contract may
24 provide that payment will be made for medical services rendered to a
25 subscriber and any of those dependents defined in section 1 of this act.
26 Whenever, pursuant to the provisions of a subscription certificate
27 or group contract issued by a corporation, the former spouse of a
28 named subscriber under such a certificate or contract is no longer
29 entitled to coverage as an eligible dependent by reason of divorce,
30 separate coverage for such former spouse shall be made available by
31 the corporation on an individual nongroup basis under the following
32 conditions:
33 (a) Application for such nongroup coverage shall be made to the
34 corporation by or on behalf of such former spouse no later than 31
35 days following the date his or her coverage under the prior certificate
36 or contract terminated.
37 (b) No new evidence of insurability shall be required in connection
38 with the application for such nongroup coverage but any health
39 exception, limitation or exclusion applicable to said former spouse
40 under the prior coverage may, at the option of the corporation, be
41 carried over to the new nongroup coverage.
42 (c) The effective date of the new coverage shall be the day
43 following the date on which such former spouse's coverage under the
44 prior certificate or contract terminated.
45 (d) The benefits provided under the nongroup coverage issued to
46 such former spouse shall be at least equal to the basic benefits
47 provided in contracts then being issued by the corporation to new
48 nongroup applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the service corporation within [31] [1][61] 60[1] days after the date of birth in order to have the coverage continue beyond such [31] [1][61] 60[1]-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] [1][61] 60[1] days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors, required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

(cf: P.L.2010, c.50, s.5)

4. Section 1 of P.L.1964, c.105 (C.17:48A-7.1) is amended to read as follows:

1. A medical service corporation may issue to a policyholder a group contract, covering at least 10 employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance (hereinafter called the commissioner) determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within [31] [1][61] 60[1] days after the date of birth in order to have the coverage continue beyond such [31] [1][61] 60[1]-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] [1][61] 60[1] days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such condition, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing

provisions of this paragraph shall apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall, subject to payment of the appropriate premium, provide that such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the individual proprietor or partners of an individual proprietorship or a partnership. The contract may provide that the term "employees" shall include retired employees. A contract issued to trustees may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A contract issued to the trustees of a fund established by the members of an association of employers may provide that the term "employees" shall include the employees of the association.

(cf: P.L.2010, c.50, s.6)

5. Section 20 of P.L.1985, c.236 (C.17:48E-20) is amended to read as follows:

20. a. Family type individual contracts shall provide that the coverage applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse, from the moment of birth. Coverage for newly-born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide coverage for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the health service corporation within ⟦31⟧ [1]⟦61⟧ 60[1] days after the date of birth in order to have the coverage continue beyond such ⟦31⟧ [1]⟦61⟧ 60[1]-day period.

b. Nonfamily type individual contracts which provide for coverage to the subscriber but not to family members or dependents of

1 that subscriber shall also provide coverage to newly-born children of
2 the subscriber, which shall commence with the moment of birth of
3 each child and shall consist of coverage of injury or sickness including
4 the necessary care and treatment of medically diagnosed congenital
5 abnormalities, if application therefor and payment of the required
6 subscription amount are made to include in the contract the coverage
7 described in subsection a. of this section within [31] [1][61] 60[1] days
8 from the date of birth of a newborn child.
9 (cf: P.L.1985, c.236, s.20)
10
11 6. Section 28 of P.L.1985, c.236 (C.17:48E-28) is amended to
12 read as follows:
13 28. a. Family type group coverage shall provide that the coverage
14 applicable for children shall be payable with respect to a newly-born
15 child of the subscriber, or his or her spouse, from the moment of birth.
16 The coverage for newly-born children shall consist of coverage of
17 injury or sickness including the necessary care and treatment of
18 medically diagnosed congenital defects and abnormalities. If a
19 subscription payment is required to obtain coverage for a child, the
20 contract may require that notification of birth of a newly-born child
21 and the required payment shall be furnished to the health service
22 corporation within [31] [1][61] 60[1] days after the date of birth in order
23 to have the coverage continue beyond that [31] [1][61] 60[1]-day period.
24 b. Non-family type group coverage, other than under contracts
25 which provide no dependent coverage whatsoever for the subscriber's
26 class, shall also provide coverage for newly-born children of the
27 subscriber, which coverage shall commence with the moment of birth
28 of each child and shall consist of coverage of injury or sickness,
29 including the necessary care and treatment of medically diagnosed
30 congenital defects and abnormalities, if application therefor and
31 payment of the required subscription amount are made to include in
32 the contract the coverage described in subsection a. of this section
33 within [31] [1][61] 60[1] days from the date of birth of a newborn child.
34 (cf: P.L.1985, c.236, s.28)
35
36 7. N.J.S.17B:26-2 is amended to read as follows:
37 17B:26-2. a. No such policy of insurance shall be delivered or
38 issued for delivery to any person in this State unless:
39 (1) The entire money and other considerations therefor are
40 expressed therein; and
41 (2) The time at which the insurance takes effect and terminates is
42 expressed therein; and
43 (3) It purports to insure only one person, except that a policy may
44 insure, originally or by subsequent amendment, upon the application
45 of an adult member of a family who shall be deemed the policyholder,
46 any two or more eligible members of that family, including husband,
47 wife, dependent children or any children under a specified age which

1 shall not exceed 19 years and any other person dependent upon the
2 policyholder; and
3 (4) The style, arrangement and over-all appearance of the policy
4 give no undue prominence to any portion of the text, and unless every
5 printed portion of the text of the policy and of any endorsements or
6 attached papers is plainly printed in light-faced type of a style in
7 general use, the size of which shall be uniform and not less than 10-
8 point with a lower-case unspaced alphabet length not less than 120-
9 point (the "text" shall include all printed matter except the name and
10 address of the insurer, name or title of the policy, the brief description
11 if any, and captions and subcaptions); and
12 (5) The exceptions and reductions of indemnity are set forth in the
13 policy and, except those which are set forth in sections 17B:26-3 to
14 17B:26-31 inclusive, are printed, at the insurer's option, either
15 included with the benefit provision to which they apply, or under an
16 appropriate caption such as "exceptions," or "exceptions and
17 reductions," provided that if an exception or reduction specifically
18 applies only to a particular benefit of the policy, a statement of such
19 exception or reduction shall be included with the benefit provision to
20 which it applies; and
21 (6) Each such form, including riders and endorsements, shall be
22 identified by a form number in the lower left-hand corner of the first
23 page thereof; and
24 (7) It contains no provision purporting to make any portion of the
25 charter, rules, constitution, or bylaws of the insurer a part of the policy
26 unless such portion is set forth in full in the policy, except in the case
27 of the incorporation of, or reference to, a statement of rates or
28 classification of risks, or short-rate table filed with the commissioner.
29 b. A policy under which coverage of a dependent of the
30 policyholder terminates at a specified age shall, with respect to an
31 unmarried child covered by the policy prior to the attainment of age
32 19, who is incapable of self-sustaining employment by reason of
33 intellectual disability or physical handicap and who became so
34 incapable prior to attainment of age 19 and who is chiefly dependent
35 upon such policyholder for support and maintenance, not so terminate
36 while the policy remains in force and the dependent remains in such
37 condition, if the policyholder has within 31 days of such dependent's
38 attainment of the limiting age submitted proof of such dependent's
39 incapacity as described herein. The foregoing provisions of this
40 paragraph shall not require an insurer to insure a dependent who is a
41 child with an intellectual disability or physical handicap where the
42 policy is underwritten on evidence of insurability based on health
43 factors set forth in the application or where such dependent does not
44 satisfy the conditions of the policy as to any requirement for evidence
45 of insurability or other provisions of the policy, satisfaction of which is
46 required for coverage thereunder to take effect. In any such case the
47 terms of the policy shall apply with regard to the coverage or exclusion
48 from coverage of such dependent.

c. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any optometric service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist.

d. If any policy is issued by an insurer domiciled in this State for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection a. of this section and in sections 17B:26-3 to 17B:26-31 inclusive.

e. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any psychological service which is within the lawful scope of practice of a duly licensed psychologist, the insured under such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed psychologist.

f. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, the insured under such policy or the chiropractor rendering such service shall be entitled to reimbursement for such service, when the said service is performed by a chiropractor. The foregoing provision shall be liberally construed in favor of reimbursement of chiropractors.

g. All individual health insurance policies which provide coverage for a family member or dependent of the insured on an expense incurred basis shall also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of that insured from the moment of birth.

(1) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(2) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within [31] [1][61] 60[1] days after the date of birth in order to have the coverage continue beyond such [31] [1][61] 60[1]-day period.

h. All individual health insurance policies which provide coverage on an expense incurred basis but do not provide coverage for a family member or dependent of the insured on an expense incurred basis shall nevertheless provide for coverage of newborn children of

the insured which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application therefor and payment of the required premium are made to the insurer to include in said policy coverage the same or similar to that of the insured, described in g. (1) above ⟦31⟧ [1]⟦<u>61</u>⟧ <u>60</u>[1] days from the date of a newborn child.

i. Whenever, pursuant to the provisions of an individual or group contract issued by an insurer, the former spouse of a named insured is no longer entitled to coverage as an individual dependent by reason of divorce, separate coverage for such former spouse shall be made available by the insurer on an individual non-group basis under the following conditions:

(1) Application for such non-group coverage shall be made to the insurer by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(2) No new evidence of insurability shall be required in connection with the application for such non-group coverage but any health exception, limitation or exclusion applicable to said former spouse under the prior coverage may, at the option of the insurer, be carried over to the new non-group coverage.

(3) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(4) The benefits provided under the non-group coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the insurer to acceptable new non-group applicants of the same age and family status.

(cf: P.L.2010, c.50, s.9)

8. N.J.S.17B:27-30 is amended to read as follows:

17B:27-30. Benefits of group health insurance, except benefits for loss of time on account of disability, may be provided for one or more members of the families or one or more dependents of persons who may be insured under a group policy referred to in section 17B:27-27, 17B:27-28 or 17B:27-29. Any group health insurance policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group must, subject to payment of the appropriate premium, permit such family members or dependents to have coverage continued for at least 180 days after the death of the person in the insured group, subject to the policy provision as to termination of coverage with respect to family members or dependents for reasons other than the death of the person in the insured group.

All group health insurance policies which provide coverage for a family member or dependent of an insured on an expense incurred basis shall also provide that the benefits applicable for children shall be payable with respect to a newly-born child of that insured from the moment of birth. The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly-born child and payment of the required premium must be furnished to the insurer within [31] [1][61] 60[1]days after the date of birth in order to have the coverage continue beyond such [31] [1][61] 60[1]-day period.

All group health insurance policies which provide coverage on an expense incurred basis for the insured but do not provide coverage for a family member or dependent of the insured on an expense incurred basis, except such group policies as provide no dependent coverage whatsoever for the insured's class, shall nevertheless provide for coverage of newborn children of the insured which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application and payment of the required premium are made to the insurer to include in said policy coverage for a newly-born child as described in the previous paragraph of this section within [31] [1][61] 60[1] days from the date of birth of a newborn child.

A policy under which coverage of a dependent of an employee or other member of the insured group terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such employee or member for support and maintenance, not so terminate while the insurance of the employee or member remains in force and the dependent remains in such condition, if the insured employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provision of this paragraph shall not require an insurer to insure a dependent who is a child with an intellectual disability or physical handicap of an employee or other member of the insured group where such dependent does not satisfy the conditions of the group policy as to any requirements for evidence of insurability or other provisions as may be stated in the group policy required for coverage thereunder to take effect. In any such case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent.

(cf: P.L.2010, c.50, s.10)

1 9. Section 16 of P.L.1997, c.146 (C.17B:27-56) is amended to
2 read as follows:
3 16. A health insurer which offers a group health plan shall not
4 impose a preexisting condition exclusion for the following: a. on a
5 newborn child who, as of the last day of the 【30】 60-day period
6 beginning with the date of birth, is covered under creditable coverage;
7 b. on a child who is adopted or placed for adoption before attaining 18
8 years of age and who, as of the last day of the 30-day period beginning
9 on the date of adoption or placement for adoption, is covered under
10 creditable coverage. These provisions shall not apply to a newborn
11 child or child who is adopted or placed for adoption after the end of
12 the first 63-day period, during all of which the newborn child or child
13 who is adopted or placed for adoption was not covered under any
14 creditable coverage; or c. pregnancy as a preexisting condition.
15 (cf: P.L.1997, c.146, s.16)
16
17 10. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to
18 read as follows:
19 6. a. No health benefits plan subject to this act shall include any
20 provision excluding coverage for a preexisting condition regardless of
21 the cause of the condition, provided that a preexisting condition
22 provision may apply to a late enrollee or to any group of two to five
23 persons if such provision excludes coverage for a period of no more
24 than 180 days following the effective date of coverage of such
25 enrollee, and relates only to conditions, whether physical or mental,
26 manifesting themselves during the six months immediately preceding
27 the enrollment date of such enrollee and for which medical advice,
28 diagnosis, care, or treatment was recommended or received during the
29 six months immediately preceding the effective date of coverage;
30 provided that, if 10 or more late enrollees request enrollment during
31 any 30-day enrollment period, then no preexisting condition provision
32 shall apply to any such enrollee.
33 b. In determining whether a preexisting condition provision
34 applies to an eligible employee or dependent, all health benefits plans
35 shall credit the time that person was covered under creditable coverage
36 if the creditable coverage was continuous to a date not more than 90
37 days prior to the effective date of the new coverage, exclusive of any
38 applicable waiting period under such plan. A carrier shall provide
39 credit pursuant to this provision in one of the following methods:
40 (1) A carrier shall count a period of creditable coverage without
41 regard to the specific benefits covered during the period; or
42 (2) A carrier shall count a period of creditable coverage based on
43 coverage of benefits within each of several classes or categories of
44 benefits specified in federal regulation rather than the method provided
45 in paragraph (1) of this subsection. This election shall be made on a
46 uniform basis for all covered persons. Under this election, a carrier
47 shall count a period of creditable coverage with respect to any class or
48 category of benefits if any level of benefits is covered within that class

1 or category. A carrier which elects to provide credit pursuant to this
2 provision shall comply with all federal notice requirements.
3 c. A health benefits plan shall not impose a preexisting condition
4 exclusion for the following:
5 (1) A newborn child who, as of the last date of the 【30】 60-day
6 period beginning with the date of birth, is covered under creditable
7 coverage;
8 (2) A child who is adopted or placed for adoption before attaining
9 18 years of age and who, as of the last day of the 30-day period
10 beginning on the date of the adoption or placement for adoption, is
11 covered under creditable coverage. This provision shall not apply to
12 coverage before the date of the adoption or placement for adoption; or
13 (3) Pregnancy as a preexisting condition.
14 (cf: P.L.1997, c.146, s.9)
15
16 11. This act shall take effect immediately.
17
18
19 ________________
20
21 Extends health benefits coverage of a newborn infant.

ASSEMBLY, No. 2665

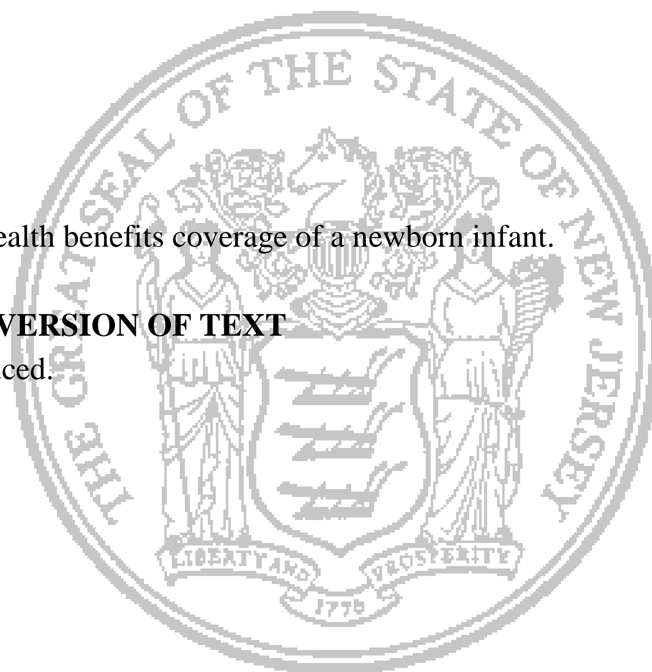
STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED FEBRUARY 8, 2016

Sponsored by:
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
Assemblywoman NANCY J. PINKIN
District 18 (Middlesex)
Assemblyman RAJ MUKHERJI
District 33 (Hudson)
Assemblyman ANDREW ZWICKER
District 16 (Hunterdon, Mercer, Middlesex and Somerset)
Assemblywoman JOANN DOWNEY
District 11 (Monmouth)
Assemblywoman ANGELA V. MCKNIGHT
District 31 (Hudson)

Co-Sponsored by:
Assemblyman Chiaravalloti, Assemblywoman Spencer and Assemblyman Conaway



SYNOPSIS
Extends health benefits coverage of a newborn infant.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 6/17/2016)

1 **AN ACT** extending the health benefits coverage of a newborn infant
2 and amending various parts of 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 6 of P.L.1938, c.366 (C.17:48-6) is amended to read
8 as follows:
9 6. Every individual contract made by a corporation subject to
10 the provisions of this chapter to furnish services to a subscriber
11 shall provide for the furnishing of services for a period of 12
12 months, and no contract shall be made providing for the inception
13 of such services at a date later than 1 year after the actual date of
14 the making of such contract. Any such contract may provide that it
15 shall be automatically renewed from year to year unless there shall
16 have been at least 30 days' prior written notice of termination by
17 either the subscriber or the corporation. In the absence of fraud or
18 material misrepresentation in the application for a contract or for
19 reinstatement, no contract with an individual subscriber shall be
20 terminated by the corporation unless all contracts of the same type,
21 in the same group or covering the same classification of persons are
22 terminated under the same conditions.
23 No contract between any such corporation and a subscriber shall
24 entitle more than one person to services, except that a contract
25 issued as a family contract may provide that services will be
26 furnished to a husband and wife, or husband, wife and their
27 dependent child or children, or the subscriber and his (or her)
28 dependent child or children. Adult dependent(s) of a subscriber
29 may also be included for coverage under the contract of such
30 subscriber.
31 Whenever, pursuant to the provisions of a subscription certificate
32 or group contract issued by a corporation, the former spouse of a
33 named subscriber under such a certificate or contract is no longer
34 entitled to coverage as an eligible dependent by reason of divorce,
35 separate coverage for such former spouse shall be made available
36 by the corporation on an individual non-group basis under the
37 following conditions:
38 (a) Application for such non-group coverage shall be made to
39 the corporation by or on behalf of such former spouse no later than
40 31 days following the date his or her coverage under the prior
41 certificate or contract terminated.
42 (b) No new evidence of insurability shall be required in
43 connection with the application for such non-group coverage but
44 any health exception, limitation or exclusion applicable to said

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 former spouse under the prior coverage may, at the option of the
2 corporation, be carried over to the new non-group coverage.
3 (c) The effective date of the new coverage shall be the day
4 following the date on which such former spouse's coverage under
5 the prior certificate or contract terminated.
6 (d) The benefits provided under the non-group coverage issued
7 to such former spouse shall be at least equal to the basic benefits
8 provided in contracts then being issued by the corporation to new
9 non-group applicants of the same age and family status.
10 Family type contracts shall provide that the services applicable
11 for children shall be payable with respect to a newly-born child of
12 the subscriber, or his or her spouse from the moment of birth. The
13 services for newly-born children shall consist of coverage of injury
14 or sickness including the necessary care and treatment of medically
15 diagnosed congenital defects and abnormalities. If a subscription
16 payment is required to provide services for a child, the contract may
17 require that notification of birth of a newly-born child and the
18 required payment must be furnished to the service corporation
19 within [31] 61 days after the date of birth in order to have the
20 coverage continue beyond such [31] 61-day period.
21 Nonfamily type contracts which provide for services to the
22 subscriber but not to family members or dependents of that
23 subscriber, shall also provide services to newly-born children of the
24 subscriber which shall commence with the moment of birth of each
25 child and shall consist of coverage of injury or sickness including
26 the necessary care and treatment of medically diagnosed congenital
27 defects and abnormalities, provided that application therefor and
28 payment of the required subscription amount are made to include in
29 said contract the coverage described in the preceding paragraph of
30 this section within [31] 61 days from the date of birth of a newborn
31 child.
32 A contract under which coverage of a dependent of a subscriber
33 terminates at a specified age shall, with respect to an unmarried
34 child, covered by the contract prior to attainment of age 19, who is
35 incapable of self-sustaining employment by reason of an intellectual
36 disability or physical handicap and who became so incapable prior
37 to attainment of age 19 and who is chiefly dependent upon such
38 subscriber for support and maintenance, not so terminate while the
39 contract remains in force and the dependent remains in such
40 condition, if the subscriber has within 31 days of such dependent's
41 attainment of the termination age submitted proof of such
42 dependent's incapacity as described herein. The foregoing
43 provisions of this paragraph shall not apply retrospectively or
44 prospectively to require a hospital service corporation to insure as a
45 covered dependent any child with an intellectual disability or
46 physically handicapped child of the applicant where the contract is
47 underwritten on evidence of insurability based on health factors
48 required to be set forth in the application. In such cases any

1 contract heretofore or hereafter issued may specifically exclude
2 such child with an intellectual disability or physically handicapped
3 child from coverage.
4 Every individual contract entered into by any such corporation
5 with any subscriber thereto shall be in writing and a certificate
6 stating the terms and conditions thereof shall be furnished to the
7 subscriber to be kept by him. No such certificate form shall be
8 made, issued or delivered in this State unless it contains the
9 following provisions:
10 (a) A statement of the contract rate, or amount payable to the
11 corporation by or on behalf of the subscriber for the original
12 quarter-annual period of coverage and of the time or times at which,
13 and the manner in which, such amount is to be paid; and a provision
14 requiring 30 days' written notice to the subscriber before any
15 change in the contract, including a change in the amount of
16 subscription rate, shall take effect;
17 (b) A statement of the nature of the services to be furnished and
18 the period during which they will be furnished; and if there are any
19 services to be excepted, a detailed statement of such exceptions
20 printed as hereinafter specified;
21 (c) A statement of the terms and conditions, if any, upon which
22 the contract may be amended on approval of the commissioner or
23 canceled or otherwise terminated at the option of either party. Any
24 notice to the subscriber shall be effective if sent by mail to the
25 subscriber's address as shown at the time on the plan's record,
26 except that, in the case of persons for whom payment of the contract
27 is made through a remitting agent, any such notice to the subscriber
28 shall also be effective if a personalized notice is sent to the
29 remitting agent for delivery to the subscriber, in which case it shall
30 be the responsibility of the remitting agent to make such delivery.
31 The notice to the subscriber as herein required shall be sent at least
32 30 days before the amendment, cancellation or termination of the
33 contract takes effect. Any rider or endorsement accompanying such
34 notice, and amending the rates or other provisions of the contract,
35 shall be deemed to be a part of the contract as of the effective date
36 of such rider or endorsement;
37 (d) A statement that the contract includes the endorsements
38 thereon and attached papers, if any, and contains the entire contract
39 for services;
40 (e) A statement that no statement by the subscriber in his
41 application for a contract shall avoid the contract or be used in any
42 legal proceeding thereunder, unless such application or an exact
43 copy thereof is included in or attached to such contract, and that no
44 agent or representative of such corporation, other than an officer or
45 officers designated therein, is authorized to change the contract or
46 waive any of its provisions;
47 (f) A statement that if the subscriber defaults in making any
48 payment under the contract, the subsequent acceptance of a

1 payment by the corporation or by one of its duly authorized agents
2 shall reinstate the contract, but with respect to sickness and injury
3 may cover such sickness as may be first manifested more than 10
4 days after the date of such acceptance;
5 (g) A statement of the period of grace which will be allowed the
6 subscriber for making any payment due under the contract. Such
7 period shall be not less than 10 days.
8 In every such contract made, issued or delivered in this State:
9 (a) All printed portions shall be plainly printed in type of which
10 the face is not smaller than 10 point;
11 (b) There shall be a brief description of the contract on its first
12 page and on its filing back in type of which the face is not smaller
13 than 14 point;
14 (c) The exceptions of the contract shall appear with the same
15 prominence as the benefits to which they apply; and
16 (d) If the contract contains any provision purporting to make
17 any portion of the articles, constitution or bylaws of the corporation
18 a part of the contract, such portion shall be set forth in full.
19 (cf: P.L.2010, c.50, s.3)
20
21 2. Section 2 of P.L.1964, c.104 (C.17:48-6.1) is amended to
22 read as follows:
23 2. A hospital service corporation may issue to a policyholder a
24 group contract, covering at least two employees or members at the
25 date of issue, if it conforms to the following description:
26 (a) A contract issued to an employer or to the trustees of a fund
27 established by one or more employers, or issued to a labor union, or
28 issued to an association formed for purposes other than obtaining
29 such contract, or issued to the trustees of a fund established by one
30 or more labor unions, or by one or more employers and one or more
31 labor unions, covering employees and members of associations or
32 labor unions.
33 (b) A contract issued to cover any other group which the
34 Commissioner of Banking and Insurance determines may be
35 covered in accordance with sound underwriting principles.
36 Benefits may be provided for one or more members of the
37 families or one or more dependents of persons who may be covered
38 under a group contract referred to in (a) or (b) above.
39 Family type contracts shall provide that the services applicable
40 for children shall be payable with respect to a newly-born child of
41 the subscriber, or his or her spouse from the moment of birth. The
42 services for newly-born children shall consist of coverage of injury
43 or sickness including the necessary care and treatment of medically
44 diagnosed congenital defects and abnormalities. If a subscription
45 payment is required to provide services for a child, the contract may
46 require that notification of birth of a newly-born child and the
47 required payment must be furnished to the service corporation

within [31] 61 days after the date of birth in order to have the coverage continue beyond such [31] 61-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] 61 days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such conditions, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a hospital service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall provide that, subject to payment of the appropriate premium, such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the

1 individual proprietor or partners of an individual proprietorship or a
2 partnership. The contract may provide that the term "employees"
3 shall include retired employees. A contract issued to trustees may
4 provide that the term "employees" shall include the trustees or their
5 employees, or both, if their duties are principally connected with
6 such trusteeship. A contract issued to the trustees of a fund
7 established by the members of an association of employers may
8 provide that the term "employees" shall include the employees of
9 the association.
10 (cf: P.L.2010, c.50, s.4)
11
12 3. Section 5 of P.L.1940, c.74 (C.17:48A-5) is amended to read
13 as follows:
14 5. Every individual contract made by any corporation subject to
15 the provisions of this chapter to provide payment for medical
16 services shall provide for the payment of medical services for a
17 period of 12 months from the date of issue of the subscription
18 certificate. Any such contract may provide that it shall be
19 automatically renewed from year to year unless there shall have
20 been 1 month's prior written notice of termination by either the
21 subscriber or the corporation. In the absence of fraud or material
22 misrepresentation in the application for contract or for
23 reinstatement, no contract with an individual subscriber shall be
24 terminated by the corporation unless all contracts of the same type,
25 in the same group or covering the same classification of persons are
26 terminated under the same conditions. No contract between such
27 corporation and subscriber shall allow for the payment for medical
28 services for more than one person, except that a family contract
29 may provide that payment will be made for medical services
30 rendered to a subscriber and any of those dependents defined in
31 section 1 of this act.
32 Whenever, pursuant to the provisions of a subscription certificate
33 or group contract issued by a corporation, the former spouse of a
34 named subscriber under such a certificate or contract is no longer
35 entitled to coverage as an eligible dependent by reason of divorce,
36 separate coverage for such former spouse shall be made available
37 by the corporation on an individual nongroup basis under the
38 following conditions:
39 (a) Application for such nongroup coverage shall be made to the
40 corporation by or on behalf of such former spouse no later than 31
41 days following the date his or her coverage under the prior
42 certificate or contract terminated.
43 (b) No new evidence of insurability shall be required in
44 connection with the application for such nongroup coverage but any
45 health exception, limitation or exclusion applicable to said former
46 spouse under the prior coverage may, at the option of the
47 corporation, be carried over to the new nongroup coverage.

(c) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(d) The benefits provided under the nongroup coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the corporation to new nongroup applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the service corporation within [31] 61 days after the date of birth in order to have the coverage continue beyond such [31] 61-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] 61 days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors, required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude

such child with an intellectual disability or physical handicap from coverage.
(cf: P.L.2010, c.50, s.5)

4. Section 1 of P.L.1964, c.105 (C.17:48A-7.1) is amended to read as follows:

1. A medical service corporation may issue to a policyholder a group contract, covering at least 10 employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance (hereinafter called the commissioner) determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within [31] 61 days after the date of birth in order to have the coverage continue beyond such [31] 61-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] 61 days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered

by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such condition, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall, subject to payment of the appropriate premium, provide that such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the individual proprietor or partners of an individual proprietorship or a partnership. The contract may provide that the term "employees" shall include retired employees. A contract issued to trustees may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A contract issued to the trustees of a fund established by the members of an association of employers may provide that the term "employees" shall include the employees of the association.

(cf: P.L.2010, c.50, s.6)

5. Section 20 of P.L.1985, c.236 (C.17:48E-20) is amended to read as follows:

20. a. Family type individual contracts shall provide that the coverage applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse, from the

1 moment of birth. Coverage for newly-born children shall consist of
2 coverage of injury or sickness, including the necessary care and
3 treatment of medically diagnosed congenital defects and
4 abnormalities. If a subscription payment is required to provide
5 coverage for a child, the contract may require that notification of
6 birth of a newly-born child and the required payment must be
7 furnished to the health service corporation within 【31】 61 days
8 after the date of birth in order to have the coverage continue beyond
9 such 【31】 61-day period.
10 b. Nonfamily type individual contracts which provide for
11 coverage to the subscriber but not to family members or dependents
12 of that subscriber shall also provide coverage to newly-born
13 children of the subscriber, which shall commence with the moment
14 of birth of each child and shall consist of coverage of injury or
15 sickness including the necessary care and treatment of medically
16 diagnosed congenital abnormalities, if application therefor and
17 payment of the required subscription amount are made to include in
18 the contract the coverage described in subsection a. of this section
19 within 【31】 61 days from the date of birth of a newborn child.
20 (cf: P.L.1985, c.236, s.20)
21
22 6. Section 28 of P.L.1985, c.236 (C.17:48E-28) is amended to
23 read as follows:
24 28. a. Family type group coverage shall provide that the
25 coverage applicable for children shall be payable with respect to a
26 newly-born child of the subscriber, or his or her spouse, from the
27 moment of birth. The coverage for newly-born children shall
28 consist of coverage of injury or sickness including the necessary
29 care and treatment of medically diagnosed congenital defects and
30 abnormalities. If a subscription payment is required to obtain
31 coverage for a child, the contract may require that notification of
32 birth of a newly-born child and the required payment shall be
33 furnished to the health service corporation within 【31】 61 days
34 after the date of birth in order to have the coverage continue beyond
35 that 【31】 61-day period.
36 b. Non-family type group coverage, other than under contracts
37 which provide no dependent coverage whatsoever for the
38 subscriber's class, shall also provide coverage for newly-born
39 children of the subscriber, which coverage shall commence with the
40 moment of birth of each child and shall consist of coverage of
41 injury or sickness, including the necessary care and treatment of
42 medically diagnosed congenital defects and abnormalities, if
43 application therefor and payment of the required subscription
44 amount are made to include in the contract the coverage described
45 in subsection a. of this section within 【31】 61 days from the date of
46 birth of a newborn child.
47 (cf: P.L.1985, c.236, s.28)

1 7. N.J.S.17B:26-2 is amended to read as follows:
2 17B:26-2. a. No such policy of insurance shall be delivered or
3 issued for delivery to any person in this State unless:
4 (1) The entire money and other considerations therefor are
5 expressed therein; and
6 (2) The time at which the insurance takes effect and terminates
7 is expressed therein; and
8 (3) It purports to insure only one person, except that a policy
9 may insure, originally or by subsequent amendment, upon the
10 application of an adult member of a family who shall be deemed the
11 policyholder, any two or more eligible members of that family,
12 including husband, wife, dependent children or any children under a
13 specified age which shall not exceed 19 years and any other person
14 dependent upon the policyholder; and
15 (4) The style, arrangement and over-all appearance of the policy
16 give no undue prominence to any portion of the text, and unless
17 every printed portion of the text of the policy and of any
18 endorsements or attached papers is plainly printed in light-faced
19 type of a style in general use, the size of which shall be uniform and
20 not less than 10-point with a lower-case unspaced alphabet length
21 not less than 120-point (the "text" shall include all printed matter
22 except the name and address of the insurer, name or title of the
23 policy, the brief description if any, and captions and subcaptions);
24 and
25 (5) The exceptions and reductions of indemnity are set forth in
26 the policy and, except those which are set forth in sections 17B:26-
27 3 to 17B:26-31 inclusive, are printed, at the insurer's option, either
28 included with the benefit provision to which they apply, or under an
29 appropriate caption such as "exceptions," or "exceptions and
30 reductions," provided that if an exception or reduction specifically
31 applies only to a particular benefit of the policy, a statement of
32 such exception or reduction shall be included with the benefit
33 provision to which it applies; and
34 (6) Each such form, including riders and endorsements, shall be
35 identified by a form number in the lower left-hand corner of the
36 first page thereof; and
37 (7) It contains no provision purporting to make any portion of
38 the charter, rules, constitution, or bylaws of the insurer a part of the
39 policy unless such portion is set forth in full in the policy, except in
40 the case of the incorporation of, or reference to, a statement of rates
41 or classification of risks, or short-rate table filed with the
42 commissioner.
43 b. A policy under which coverage of a dependent of the
44 policyholder terminates at a specified age shall, with respect to an
45 unmarried child covered by the policy prior to the attainment of age
46 19, who is incapable of self-sustaining employment by reason of
47 intellectual disability or physical handicap and who became so
48 incapable prior to attainment of age 19 and who is chiefly

1 dependent upon such policyholder for support and maintenance, not
2 so terminate while the policy remains in force and the dependent
3 remains in such condition, if the policyholder has within 31 days of
4 such dependent's attainment of the limiting age submitted proof of
5 such dependent's incapacity as described herein. The foregoing
6 provisions of this paragraph shall not require an insurer to insure a
7 dependent who is a child with an intellectual disability or physical
8 handicap where the policy is underwritten on evidence of
9 insurability based on health factors set forth in the application or
10 where such dependent does not satisfy the conditions of the policy
11 as to any requirement for evidence of insurability or other
12 provisions of the policy, satisfaction of which is required for
13 coverage thereunder to take effect. In any such case the terms of
14 the policy shall apply with regard to the coverage or exclusion from
15 coverage of such dependent.
16 c. Notwithstanding any provision of a policy of health
17 insurance, hereafter delivered or issued for delivery in this State,
18 whenever such policy provides for reimbursement for any
19 optometric service which is within the lawful scope of practice of a
20 duly licensed optometrist, the insured under such policy shall be
21 entitled to reimbursement for such service, whether the said service
22 is performed by a physician or duly licensed optometrist.
23 d. If any policy is issued by an insurer domiciled in this State
24 for delivery to a person residing in another state, and if the official
25 having responsibility for the administration of the insurance laws of
26 such other state shall have advised the commissioner that any such
27 policy is not subject to approval or disapproval by such official, the
28 commissioner may by ruling require that such policy meet the
29 standards set forth in subsection a. of this section and in sections
30 17B:26-3 to 17B:26-31 inclusive.
31 e. Notwithstanding any provision of a policy of health
32 insurance, hereafter delivered or issued for delivery in this State,
33 whenever such policy provides for reimbursement for any
34 psychological service which is within the lawful scope of practice
35 of a duly licensed psychologist, the insured under such policy shall
36 be entitled to reimbursement for such service, whether the said
37 service is performed by a physician or duly licensed psychologist.
38 f. Notwithstanding any provision of a policy of health
39 insurance, hereafter delivered or issued for delivery in this State,
40 whenever such policy provides for reimbursement for any service
41 which is within the lawful scope of practice of a duly licensed
42 chiropractor, the insured under such policy or the chiropractor
43 rendering such service shall be entitled to reimbursement for such
44 service, when the said service is performed by a chiropractor. The
45 foregoing provision shall be liberally construed in favor of
46 reimbursement of chiropractors.
47 g. All individual health insurance policies which provide
48 coverage for a family member or dependent of the insured on an

1 expense incurred basis shall also provide that the health insurance
2 benefits applicable for children shall be payable with respect to a
3 newly born child of that insured from the moment of birth.
4 (1) The coverage for newly born children shall consist of
5 coverage of injury or sickness including the necessary care and
6 treatment of medically diagnosed congenital defects and birth
7 abnormalities.
8 (2) If payment of a specific premium is required to provide
9 coverage for a child, the policy may require that notification of
10 birth of a newly born child and payment of the required premium
11 must be furnished to the insurer within [31] 61 days after the date
12 of birth in order to have the coverage continue beyond such [31]
13 61-day period.
14 h. All individual health insurance policies which provide
15 coverage on an expense incurred basis but do not provide coverage
16 for a family member or dependent of the insured on an expense
17 incurred basis shall nevertheless provide for coverage of newborn
18 children of the insured which shall commence with the moment of
19 birth of each child and shall consist of coverage of injury or
20 sickness including the necessary care and treatment of medically
21 diagnosed congenital defects and birth abnormalities, provided
22 application therefor and payment of the required premium are made
23 to the insurer to include in said policy coverage the same or similar
24 to that of the insured, described in g. (1) above [31] 61 days from
25 the date of a newborn child.
26 i. Whenever, pursuant to the provisions of an individual or
27 group contract issued by an insurer, the former spouse of a named
28 insured is no longer entitled to coverage as an individual dependent
29 by reason of divorce, separate coverage for such former spouse
30 shall be made available by the insurer on an individual non-group
31 basis under the following conditions:
32 (1) Application for such non-group coverage shall be made to
33 the insurer by or on behalf of such former spouse no later than 31
34 days following the date his or her coverage under the prior
35 certificate or contract terminated.
36 (2) No new evidence of insurability shall be required in
37 connection with the application for such non-group coverage but
38 any health exception, limitation or exclusion applicable to said
39 former spouse under the prior coverage may, at the option of the
40 insurer, be carried over to the new non-group coverage.
41 (3) The effective date of the new coverage shall be the day
42 following the date on which such former spouse's coverage under
43 the prior certificate or contract terminated.
44 (4) The benefits provided under the non-group coverage issued
45 to such former spouse shall be at least equal to the basic benefits
46 provided in contracts then being issued by the insurer to acceptable
47 new non-group applicants of the same age and family status.
48 (cf: P.L.2010, c.50, s.9)

1 8. N.J.S.17B:27-30 is amended to read as follows:
2 17B:27-30. Benefits of group health insurance, except benefits
3 for loss of time on account of disability, may be provided for one or
4 more members of the families or one or more dependents of persons
5 who may be insured under a group policy referred to in section
6 17B:27-27, 17B:27-28 or 17B:27-29. Any group health insurance
7 policy which contains provisions for the payment by the insurer of
8 benefits for expenses incurred on account of hospital, nursing,
9 medical, or surgical services for members of the family or
10 dependents of a person in the insured group must, subject to
11 payment of the appropriate premium, permit such family members
12 or dependents to have coverage continued for at least 180 days after
13 the death of the person in the insured group, subject to the policy
14 provision as to termination of coverage with respect to family
15 members or dependents for reasons other than the death of the
16 person in the insured group.
17 All group health insurance policies which provide coverage for a
18 family member or dependent of an insured on an expense incurred
19 basis shall also provide that the benefits applicable for children
20 shall be payable with respect to a newly-born child of that insured
21 from the moment of birth. The coverage for newly-born children
22 shall consist of coverage of injury or sickness including the
23 necessary care and treatment of medically diagnosed congenital
24 defects and birth abnormalities. If payment of a specific premium
25 is required to provide coverage for a child, the policy may require
26 that notification of birth of a newly-born child and payment of the
27 required premium must be furnished to the insurer within ⟦31⟧ <u>61</u>
28 days after the date of birth in order to have the coverage continue
29 beyond such ⟦31⟧ <u>61</u>-day period.
30 All group health insurance policies which provide coverage on
31 an expense incurred basis for the insured but do not provide
32 coverage for a family member or dependent of the insured on an
33 expense incurred basis, except such group policies as provide no
34 dependent coverage whatsoever for the insured's class, shall
35 nevertheless provide for coverage of newborn children of the
36 insured which shall commence with the moment of birth of each
37 child and shall consist of coverage of injury or sickness including
38 the necessary care and treatment of medically diagnosed congenital
39 defects and birth abnormalities, provided application and payment
40 of the required premium are made to the insurer to include in said
41 policy coverage for a newly-born child as described in the previous
42 paragraph of this section within ⟦31⟧ <u>61</u> days from the date of birth
43 of a newborn child.
44 A policy under which coverage of a dependent of an employee or
45 other member of the insured group terminates at a specified age
46 shall, with respect to an unmarried child covered by the policy prior
47 to the attainment of age 19, who is incapable of self-sustaining
48 employment by reason of intellectual disability or physical

handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such employee or member for support and maintenance, not so terminate while the insurance of the employee or member remains in force and the dependent remains in such condition, if the insured employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provision of this paragraph shall not require an insurer to insure a dependent who is a child with an intellectual disability or physical handicap of an employee or other member of the insured group where such dependent does not satisfy the conditions of the group policy as to any requirements for evidence of insurability or other provisions as may be stated in the group policy required for coverage thereunder to take effect. In any such case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent.
(cf: P.L.2010, c.50, s.10)

9. Section 16 of P.L.1997, c.146 (C.17B:27-56) is amended to read as follows:

16. A health insurer which offers a group health plan shall not impose a preexisting condition exclusion for the following: a. on a newborn child who, as of the last day of the [30] 60-day period beginning with the date of birth, is covered under creditable coverage; b. on 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 adoption or placement for adoption, is covered under creditable coverage. These provisions shall not apply to a newborn child or child who is adopted or placed for adoption after the end of the first 63-day period, during all of which the newborn child or child who is adopted or placed for adoption was not covered under any creditable coverage; or c. pregnancy as a preexisting condition.
(cf: P.L.1997, c.146, s.16)

10. 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.

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】 60-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.

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

11. This act shall take effect immediately.

STATEMENT

This bill extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a

1 private health benefits coverage policy or in a State or federal
2 program, such as FamilyCare.
3 The 30 day deadline can be problematic for some parents to meet
4 and may cause an unnecessary stress on the parents. This bill will
5 provide a longer period of time for children to be covered under
6 their parents' health benefits coverage, which will assist new
7 parents and ensure that children have access to adequate health care
8 during the critical first few months of life.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2665

STATE OF NEW JERSEY

DATED: JUNE 2, 2016

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 2665.

This bill extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as FamilyCare.

The 30 day deadline can be problematic for some parents to meet and may cause an unnecessary stress on the parents. This bill will provide a longer period of time for children to be covered under their parents' health benefits coverage, which will assist new parents and ensure that children have access to adequate health care during the critical first few months of life.

SENATE COMMERCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2665

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 4, 2017

The Senate Commerce Committee reports favorably and with committee amendments Assembly Bill No. 2665.

This amended bill extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as FamilyCare.

The 30 day deadline can be problematic for some parents to meet and may cause an unnecessary stress on the parents. This bill will provide a longer period of time for children to be covered under their parents' health benefits coverage, which will assist new parents and ensure that children have access to adequate health care during the critical first few months of life.

The bill, as amended and reported by the committee, is identical to Senate Bill No. 837, as also amended and reported by the committee.

<u>Committee amendments</u>

The committee amendments revise the numbers of days which a parent's health benefits can be extended to cover a newborn child from 61 days to 60 days in certain circumstances.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 2665

STATE OF NEW JERSEY

DATED: DECEMBER 14, 2017

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 2665 (1R).

This bill extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as FamilyCare.

The 30 day deadline can be problematic for some parents to meet and may cause an unnecessary stress on the parents. This bill will provide a longer period of time for children to be covered under their parents' health benefits coverage, which will assist new parents and ensure that children have access to adequate health care during the critical first few months of life.

As reported, this bill is identical to Senate Bill No. 837 (1R), as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill could potentially result in some costs shifting to private insurance that would otherwise be borne by the State's Medicaid, NJ FamilyCare, Charity Care, or Early Intervention System programs. The OLS is not able to estimate the fiscal impact of the bill with reasonable certainty, due to a lack of sufficient data. The bill would apply only to private health insurance policies regulated by the Department of Banking and Insurance, which do not track data on the number of births covered under these policies.

If the federal government determines that the extended coverage provided by the bill establishes a new mandated health benefit, the State would be required to pay for increased costs for this coverage provided under policies sold through the health insurance exchange established under the Affordable Care Act.

LEGISLATIVE FISCAL ESTIMATE

ASSEMBLY, No. 2665

STATE OF NEW JERSEY

217th LEGISLATURE

DATED: JUNE 20, 2016

SUMMARY

Synopsis: Extends health benefits coverage of a newborn infant.

Type of Impact: A possible net increase or decrease in State expenditures from the General Fund.

Agencies Affected: Department of Banking and Insurance; Department of Human Services; Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	**Years 1-3**
State Cost	Possible change of indeterminate direction or size – See comments below

- The bill could potentially result in some costs shifting to private insurance that would otherwise be borne by the State's Medicaid, NJ FamilyCare, Charity Care, or Early Intervention System programs.

- If the federal government determines that the extended coverage provided by the bill establishes a new mandated health benefit, the State would be required to pay for increased costs for this coverage provided under policies sold through the health insurance exchange established under the Affordable Care Act.

- The Office of Legislative Services (OLS) does not have access to data on the number of newly born children likely to be affected by the bill, or on the cost or quantity of medical services that might be shifted from the State to private payers or vice-versa.

BILL DESCRIPTION

Assembly Bill No. 2665 of 2016 extends the time period in which newly born children are covered under their parent's health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child would be without coverage unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as Medicaid or NJ FamilyCare.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS is not able to estimate the fiscal impact of the bill with reasonable certainty, due to a lack of sufficient data. The bill would apply only to private health insurance policies regulated by the Department of Banking and Insurance, which do not track data on the number of births covered under these policies. It is noted that, according to a report by the New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), approximately 65 percent of women who had a live birth from 2002 to 2005 were covered by private insurance; 32 percent were covered by NJ FamilyCare (Medicaid); and three percent were uninsured at the time of birth. The OLS has been unable to locate more recent data specific to New Jersey, but notes that the insurance market has shifted since that time, with significant growth in the NJ FamilyCare population and some decline in the privately insured and uninsured populations. The OLS also notes that only a subset of privately insured individuals would be affected by the bill, as the bill would not apply to self-insured health coverage plans or government employee or retiree health benefits plans. Approximately 100,000 to 110,000 births occur in New Jersey annually.

The bill might shift some costs related to care provided to newborns aged 31-60 days to private insurance, which would otherwise have been paid for by State-funded programs that provide care to newborn children, such as NJ FamilyCare, administered by the Department of Human Services. To provide an approximation of the cost of care that might be shifted to private insurance, it is noted that the NJ FamilyCare program spends approximately $2,230 per year for medical coverage for children (of which 50 percent or more is paid with the federal matching funds, depending on the specific part of NJ FamilyCare in which the child is enrolled). Other programs that may be affected include Charity Care and the Early Intervention System, administered by the Department of Health. Data is not available on the spending in these programs related to care for newborns aged 31-60 days, and that spending would not necessarily be replaced by private insurance if the bill were enacted.

It is also noted that section 1311 of the Affordable Care Act includes a provision (compiled at 42 U.S.C. 18031(d)(3)(B)) allowing states to impose new health insurance benefit mandates on plans sold in the health insurance exchanges; however, in such a case the law requires the State to make payments to either the individual enrolled in the plan or the qualified health plan to defray the additional costs of this coverage. The OLS does not have data on the costs that might be incurred by the State to comply with this requirement, or the administrative costs to establish and implement a system to calculate and make such payments.

Section:	*Human Services*
Analyst:	*David Drescher* *Senior Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 2665

STATE OF NEW JERSEY
217th LEGISLATURE

DATED: DECEMBER 18, 2017

SUMMARY

Synopsis: Extends health benefits coverage of a newborn infant.

Type of Impact: A possible net increase or decrease in State expenditures from the General Fund.

Agencies Affected: Department of Banking and Insurance; Department of Human Services; Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	Years 1-3
State Cost	Possible change of indeterminate direction or size – See comments below

- The bill could potentially result in some costs shifting to private insurance that would otherwise be borne by the State's Medicaid, NJ FamilyCare, Charity Care, or Early Intervention System programs.

- If the federal government determines that the extended coverage provided by the bill establishes a new mandated health benefit, the State would be required to pay for increased costs for this coverage provided under policies sold through the health insurance exchange established under the Affordable Care Act.

- The Office of Legislative Services (OLS) does not have access to data on the number of newly born children likely to be affected by the bill, or on the cost or quantity of medical services that might be shifted from the State to private payers or vice-versa.

BILL DESCRIPTION

Assembly Bill No. 2665 (1R) of 2016 extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 31 days from their birth. At the conclusion of 31 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as Medicaid or NJ FamilyCare.

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– OLS –

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FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS is not able to estimate the fiscal impact of the bill with reasonable certainty, due to a lack of sufficient data. In general, the bill might shift some costs related to care provided to newborns aged 31-60 days to private insurance, which would otherwise have been paid for by State-funded programs that provide care to newborn children, such as Medicaid and NJ FamilyCare, administered by the Department of Human Services. To provide an approximation of the cost of care that might be shifted to private insurance, it is noted that the Medicaid program spends approximately $2,700 per year for medical coverage for children (of which 50 percent or more is paid with the federal matching funds, depending on the specific part of the program in which the child is enrolled). Other programs that may be affected include Charity Care and the Early Intervention System, administered by the Department of Health. Data is not available on the spending in these programs related to care for newborns aged 31-60 days, but that spending would not necessarily be replaced by private insurance if the bill were enacted.

The OLS notes that approximately 103,000 live births occurred in New Jersey in 2014. According to the New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), approximately 61 percent of births in 2014 were covered by private insurance; 35 percent were covered by NJ FamilyCare (Medicaid); and 5 percent were uninsured at the time of birth. The bill would only apply to a subset of privately insured individuals, as the bill would not apply to self-insured health coverage plans or government employee or retiree health benefits plans. No data is available to the OLS on the number of births covered by such plans. Among the newborns whose mothers are enrolled in plans affected by the bill, only those who incur costs that would affect a State program would affect State costs, so households whose children are promptly enrolled in a family insurance policy generally would not be affected by the bill.

It is also noted that section 1311 of the federal Affordable Care Act includes a provision (compiled at 42 U.S.C. 18031(d)(3)(B)) allowing states to impose new health insurance benefit mandates on plans sold in the health insurance exchanges; however, in such a case the law requires the State to make payments to either the individual enrolled in the plan or the qualified health plan to defray the additional costs of this coverage. The OLS does not have data on the costs that might be incurred by the State to comply with this requirement, or the administrative costs to establish and implement a system to calculate and make such payments.

Section: *Human Services*

Analyst: *David Drescher*
Senior Fiscal Analyst

Approved: *Frank W. Haines III*
Legislative Budget and Finance Officer

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE, No. 837

STATE OF NEW JERSEY

217th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

Sponsored by:
Senator NELLIE POU
District 35 (Bergen and Passaic)
Senator JAMES BEACH
District 6 (Burlington and Camden)

Co-Sponsored by:
Senator Cruz-Perez

SYNOPSIS

Extends health benefits coverage of a newborn infant.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 8/2/2016)

AN ACT extending the health benefits coverage of a newborn infant and amending various parts of the statutory law.

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

1. Section 6 of P.L.1938, c.366 (C.17:48-6) is amended to read as follows:

6. Every individual contract made by a corporation subject to the provisions of this chapter to furnish services to a subscriber shall provide for the furnishing of services for a period of 12 months, and no contract shall be made providing for the inception of such services at a date later than 1 year after the actual date of the making of such contract. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been at least 30 days' prior written notice of termination by either the subscriber or the corporation. In the absence of fraud or material misrepresentation in the application for a contract or for reinstatement, no contract with an individual subscriber shall be terminated by the corporation unless all contracts of the same type, in the same group or covering the same classification of persons are terminated under the same conditions.

No contract between any such corporation and a subscriber shall entitle more than one person to services, except that a contract issued as a family contract may provide that services will be furnished to a husband and wife, or husband, wife and their dependent child or children, or the subscriber and his (or her) dependent child or children. Adult dependent(s) of a subscriber may also be included for coverage under the contract of such subscriber.

Whenever, pursuant to the provisions of a subscription certificate or group contract issued by a corporation, the former spouse of a named subscriber under such a certificate or contract is no longer entitled to coverage as an eligible dependent by reason of divorce, separate coverage for such former spouse shall be made available by the corporation on an individual non-group basis under the following conditions:

(a) Application for such non-group coverage shall be made to the corporation by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(b) No new evidence of insurability shall be required in connection with the application for such non-group coverage but any health exception, limitation or exclusion applicable to said

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.

1 former spouse under the prior coverage may, at the option of the
2 corporation, be carried over to the new non-group coverage.
3 (c) The effective date of the new coverage shall be the day
4 following the date on which such former spouse's coverage under
5 the prior certificate or contract terminated.
6 (d) The benefits provided under the non-group coverage issued
7 to such former spouse shall be at least equal to the basic benefits
8 provided in contracts then being issued by the corporation to new
9 non-group applicants of the same age and family status.
10 Family type contracts shall provide that the services applicable
11 for children shall be payable with respect to a newly-born child of
12 the subscriber, or his or her spouse from the moment of birth. The
13 services for newly-born children shall consist of coverage of injury
14 or sickness including the necessary care and treatment of medically
15 diagnosed congenital defects and abnormalities. If a subscription
16 payment is required to provide services for a child, the contract may
17 require that notification of birth of a newly-born child and the
18 required payment must be furnished to the service corporation
19 within 【31】 91 days after the date of birth in order to have the
20 coverage continue beyond such 【31】 91-day period.
21 Nonfamily type contracts which provide for services to the
22 subscriber but not to family members or dependents of that
23 subscriber, shall also provide services to newly-born children of the
24 subscriber which shall commence with the moment of birth of each
25 child and shall consist of coverage of injury or sickness including
26 the necessary care and treatment of medically diagnosed congenital
27 defects and abnormalities, provided that application therefor and
28 payment of the required subscription amount are made to include in
29 said contract the coverage described in the preceding paragraph of
30 this section within 【31】 91 days from the date of birth of a newborn
31 child.
32 A contract under which coverage of a dependent of a subscriber
33 terminates at a specified age shall, with respect to an unmarried
34 child, covered by the contract prior to attainment of age 19, who is
35 incapable of self-sustaining employment by reason of an intellectual
36 disability or physical handicap and who became so incapable prior
37 to attainment of age 19 and who is chiefly dependent upon such
38 subscriber for support and maintenance, not so terminate while the
39 contract remains in force and the dependent remains in such
40 condition, if the subscriber has within 31 days of such dependent's
41 attainment of the termination age submitted proof of such
42 dependent's incapacity as described herein. The foregoing
43 provisions of this paragraph shall not apply retrospectively or
44 prospectively to require a hospital service corporation to insure as a
45 covered dependent any child with an intellectual disability or
46 physically handicapped child of the applicant where the contract is
47 underwritten on evidence of insurability based on health factors
48 required to be set forth in the application. In such cases any

1 contract heretofore or hereafter issued may specifically exclude
2 such child with an intellectual disability or physically handicapped
3 child from coverage.
4 Every individual contract entered into by any such corporation
5 with any subscriber thereto shall be in writing and a certificate
6 stating the terms and conditions thereof shall be furnished to the
7 subscriber to be kept by him. No such certificate form shall be
8 made, issued or delivered in this State unless it contains the
9 following provisions:
10 (a) A statement of the contract rate, or amount payable to the
11 corporation by or on behalf of the subscriber for the original
12 quarter-annual period of coverage and of the time or times at which,
13 and the manner in which, such amount is to be paid; and a provision
14 requiring 30 days' written notice to the subscriber before any
15 change in the contract, including a change in the amount of
16 subscription rate, shall take effect;
17 (b) A statement of the nature of the services to be furnished and
18 the period during which they will be furnished; and if there are any
19 services to be excepted, a detailed statement of such exceptions
20 printed as hereinafter specified;
21 (c) A statement of the terms and conditions, if any, upon which
22 the contract may be amended on approval of the commissioner or
23 canceled or otherwise terminated at the option of either party. Any
24 notice to the subscriber shall be effective if sent by mail to the
25 subscriber's address as shown at the time on the plan's record,
26 except that, in the case of persons for whom payment of the contract
27 is made through a remitting agent, any such notice to the subscriber
28 shall also be effective if a personalized notice is sent to the
29 remitting agent for delivery to the subscriber, in which case it shall
30 be the responsibility of the remitting agent to make such delivery.
31 The notice to the subscriber as herein required shall be sent at least
32 30 days before the amendment, cancellation or termination of the
33 contract takes effect. Any rider or endorsement accompanying such
34 notice, and amending the rates or other provisions of the contract,
35 shall be deemed to be a part of the contract as of the effective date
36 of such rider or endorsement;
37 (d) A statement that the contract includes the endorsements
38 thereon and attached papers, if any, and contains the entire contract
39 for services;
40 (e) A statement that no statement by the subscriber in his
41 application for a contract shall avoid the contract or be used in any
42 legal proceeding thereunder, unless such application or an exact
43 copy thereof is included in or attached to such contract, and that no
44 agent or representative of such corporation, other than an officer or
45 officers designated therein, is authorized to change the contract or
46 waive any of its provisions;
47 (f) A statement that if the subscriber defaults in making any
48 payment under the contract, the subsequent acceptance of a

1 payment by the corporation or by one of its duly authorized agents
2 shall reinstate the contract, but with respect to sickness and injury
3 may cover such sickness as may be first manifested more than 10
4 days after the date of such acceptance;
5 (g) A statement of the period of grace which will be allowed the
6 subscriber for making any payment due under the contract. Such
7 period shall be not less than 10 days.
8 In every such contract made, issued or delivered in this State:
9 (a) All printed portions shall be plainly printed in type of which
10 the face is not smaller than 10 point;
11 (b) There shall be a brief description of the contract on its first
12 page and on its filing back in type of which the face is not smaller
13 than 14 point;
14 (c) The exceptions of the contract shall appear with the same
15 prominence as the benefits to which they apply; and
16 (d) If the contract contains any provision purporting to make
17 any portion of the articles, constitution or bylaws of the corporation
18 a part of the contract, such portion shall be set forth in full.
19 (cf: P.L.2010, c.50, s.3)
20
21 2. Section 2 of P.L.1964, c.104 (C.17:48-6.1) is amended to
22 read as follows:
23 2. A hospital service corporation may issue to a policyholder a
24 group contract, covering at least two employees or members at the
25 date of issue, if it conforms to the following description:
26 (a) A contract issued to an employer or to the trustees of a fund
27 established by one or more employers, or issued to a labor union, or
28 issued to an association formed for purposes other than obtaining
29 such contract, or issued to the trustees of a fund established by one
30 or more labor unions, or by one or more employers and one or more
31 labor unions, covering employees and members of associations or
32 labor unions.
33 (b) A contract issued to cover any other group which the
34 Commissioner of Banking and Insurance determines may be
35 covered in accordance with sound underwriting principles.
36 Benefits may be provided for one or more members of the
37 families or one or more dependents of persons who may be covered
38 under a group contract referred to in (a) or (b) above.
39 Family type contracts shall provide that the services applicable
40 for children shall be payable with respect to a newly-born child of
41 the subscriber, or his or her spouse from the moment of birth. The
42 services for newly-born children shall consist of coverage of injury
43 or sickness including the necessary care and treatment of medically
44 diagnosed congenital defects and abnormalities. If a subscription
45 payment is required to provide services for a child, the contract may
46 require that notification of birth of a newly-born child and the
47 required payment must be furnished to the service corporation

1 within [31] 91 days after the date of birth in order to have the
2 coverage continue beyond such [31] 91-day period.
3 Group contracts which provide for services to the subscriber but
4 not to family members or dependents of that subscriber, other than
5 contracts which provide no dependent coverage whatsoever for the
6 subscriber's class, shall also provide services to newly-born children
7 of the subscriber which shall commence with the moment of birth
8 of each child and shall consist of coverage of injury or sickness
9 including the necessary care and treatment of medically diagnosed
10 congenital defects and abnormalities, provided that application
11 therefor and payment of the required subscription amount are made
12 to include in said contract the coverage described in the preceding
13 paragraph of this section within [31] 91 days from the date of birth
14 of a newborn child.
15 A contract under which coverage of such a dependent terminates
16 at a specified age shall, with respect to an unmarried child, covered
17 by the contract prior to attainment of age 19, who is incapable of
18 self-sustaining employment by reason of intellectual disability or
19 physical handicap and who became so incapable prior to attainment
20 of age 19 and who is chiefly dependent upon the covered employee
21 or member for support and maintenance, not so terminate while the
22 coverage of the employee or member remains in force and the
23 dependent remains in such conditions, if the employee or member
24 has within 31 days of such dependent's attainment of the
25 termination age submitted proof of such dependent's incapacity as
26 described herein. The foregoing provisions of this paragraph shall
27 not apply retrospectively or prospectively to require a hospital
28 service corporation to insure as a covered dependent any child with
29 an intellectual disability or physical handicap of the applicant where
30 the contract is underwritten on evidence of insurability based on
31 health factors required to be set forth in the application. In such
32 cases any contract heretofore or hereafter issued may specifically
33 exclude such child with an intellectual disability or physical
34 handicap from coverage.
35 Any group contract which contains provisions for the payment
36 by the insurer of benefits for members of the family or dependents
37 of a person in the insured group shall provide that, subject to
38 payment of the appropriate premium, such family members or
39 dependents be permitted to have coverage continued for at least 180
40 days after the death of the person in the insured group.
41 The contract may provide that the term "employees" shall
42 include as employees of a single employer the employees of one or
43 more subsidiary corporations and the employees, individual
44 proprietors and partners of affiliated corporations, proprietorships
45 and partnerships if the business of the employer and such
46 corporations, proprietorships or partnerships is under common
47 control through stock ownership, contract or otherwise. The
48 contract may provide that the term "employees" shall include the

1 individual proprietor or partners of an individual proprietorship or a
2 partnership. The contract may provide that the term "employees"
3 shall include retired employees. A contract issued to trustees may
4 provide that the term "employees" shall include the trustees or their
5 employees, or both, if their duties are principally connected with
6 such trusteeship. A contract issued to the trustees of a fund
7 established by the members of an association of employers may
8 provide that the term "employees" shall include the employees of
9 the association.
10 (cf: P.L.2010, c.50, s.4)
11
12 3. Section 5 of P.L.1940, c.74 (C.17:48A-5) is amended to read
13 as follows:
14 5. Every individual contract made by any corporation subject to
15 the provisions of this chapter to provide payment for medical
16 services shall provide for the payment of medical services for a
17 period of 12 months from the date of issue of the subscription
18 certificate. Any such contract may provide that it shall be
19 automatically renewed from year to year unless there shall have
20 been 1 month's prior written notice of termination by either the
21 subscriber or the corporation. In the absence of fraud or material
22 misrepresentation in the application for contract or for
23 reinstatement, no contract with an individual subscriber shall be
24 terminated by the corporation unless all contracts of the same type,
25 in the same group or covering the same classification of persons are
26 terminated under the same conditions. No contract between such
27 corporation and subscriber shall allow for the payment for medical
28 services for more than one person, except that a family contract
29 may provide that payment will be made for medical services
30 rendered to a subscriber and any of those dependents defined in
31 section 1 of this act.
32 Whenever, pursuant to the provisions of a subscription certificate
33 or group contract issued by a corporation, the former spouse of a
34 named subscriber under such a certificate or contract is no longer
35 entitled to coverage as an eligible dependent by reason of divorce,
36 separate coverage for such former spouse shall be made available
37 by the corporation on an individual nongroup basis under the
38 following conditions:
39 (a) Application for such nongroup coverage shall be made to the
40 corporation by or on behalf of such former spouse no later than 31
41 days following the date his or her coverage under the prior
42 certificate or contract terminated.
43 (b) No new evidence of insurability shall be required in
44 connection with the application for such nongroup coverage but any
45 health exception, limitation or exclusion applicable to said former
46 spouse under the prior coverage may, at the option of the
47 corporation, be carried over to the new nongroup coverage.

(c) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(d) The benefits provided under the nongroup coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the corporation to new nongroup applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the service corporation within [31] 91 days after the date of birth in order to have the coverage continue beyond such [31] 91-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within [31] 91 days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors, required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude

such child with an intellectual disability or physical handicap from coverage.
(cf: P.L.2010, c.50, s.5)

4. Section 1 of P.L.1964, c.105 (C.17:48A-7.1) is amended to read as follows:

1. A medical service corporation may issue to a policyholder a group contract, covering at least 10 employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance (hereinafter called the commissioner) determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within 【31】 <u>91</u> days after the date of birth in order to have the coverage continue beyond such 【31】 <u>91</u>-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within 【31】 <u>91</u> days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered

1 by the contract prior to attainment of age 19, who is incapable of
2 self-sustaining employment by reason of intellectual disability or
3 physical handicap and who became so incapable prior to attainment
4 of age 19 and who is chiefly dependent upon the covered employee
5 or member for support and maintenance, not so terminate while the
6 coverage of the employee or member remains in force and the
7 dependent remains in such condition, if the employee or member
8 has within 31 days of such dependent's attainment of the
9 termination age submitted proof of such dependent's incapacity as
10 described herein. The foregoing provisions of this paragraph shall
11 apply retrospectively or prospectively to require a medical service
12 corporation to insure as a covered dependent any child with an
13 intellectual disability or physical handicap of the applicant where
14 the contract is underwritten on evidence of insurability based on
15 health factors required to be set forth in the application. In such
16 cases any contract heretofore or hereafter issued may specifically
17 exclude such child with an intellectual disability or physical
18 handicap from coverage.
19 Any group contract which contains provisions for the payment
20 by the insurer of benefits for members of the family or dependents
21 of a person in the insured group shall, subject to payment of the
22 appropriate premium, provide that such family members or
23 dependents be permitted to have coverage continued for at least 180
24 days after the death of the person in the insured group.
25 The contract may provide that the term "employees" shall
26 include as employees of a single employer the employees of one or
27 more subsidiary corporations and the employees, individual
28 proprietors and partners of affiliated corporations, proprietorships
29 and partnerships if the business of the employer and such
30 corporations, proprietorships or partnerships is under common
31 control through stock ownership, contract or otherwise. The
32 contract may provide that the term "employees" shall include the
33 individual proprietor or partners of an individual proprietorship or a
34 partnership. The contract may provide that the term "employees"
35 shall include retired employees. A contract issued to trustees may
36 provide that the term "employees" shall include the trustees or their
37 employees, or both, if their duties are principally connected with
38 such trusteeship. A contract issued to the trustees of a fund
39 established by the members of an association of employers may
40 provide that the term "employees" shall include the employees of
41 the association.
42 (cf: P.L.2010, c.50, s.6)
43
44 5. Section 20 of P.L.1985, c.236 (C.17:48E-20) is amended to
45 read as follows:
46 20. a. Family type individual contracts shall provide that the
47 coverage applicable for children shall be payable with respect to a
48 newly-born child of the subscriber, or his or her spouse, from the

moment of birth. Coverage for newly-born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide coverage for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the health service corporation within [31] 91 days after the date of birth in order to have the coverage continue beyond such [31] 91-day period.

b. Nonfamily type individual contracts which provide for coverage to the subscriber but not to family members or dependents of that subscriber shall also provide coverage to newly-born children of the subscriber, which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital abnormalities, if application therefor and payment of the required subscription amount are made to include in the contract the coverage described in subsection a. of this section within [31] 91 days from the date of birth of a newborn child.

(cf: P.L.1985, c.236, s.20)

6. Section 28 of P.L.1985, c.236 (C.17:48E-28) is amended to read as follows:

28. a. Family type group coverage shall provide that the coverage applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse, from the moment of birth. The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to obtain coverage for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the health service corporation within [31] 91 days after the date of birth in order to have the coverage continue beyond that [31] 91-day period.

b. Non-family type group coverage, other than under contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide coverage for newly-born children of the subscriber, which coverage shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, if application therefor and payment of the required subscription amount are made to include in the contract the coverage described in subsection a. of this section within [31] 91 days from the date of birth of a newborn child.

(cf: P.L.1985, c.236, s.28)

7. N.J.S.17B:26-2 is amended to read as follows:

17B:26-2. a. No such policy of insurance shall be delivered or issued for delivery to any person in this State unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder; and

(4) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); and

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections 17B:26-3 to 17B:26-31 inclusive, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "exceptions," or "exceptions and reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

b. A policy under which coverage of a dependent of the policyholder terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly

1 dependent upon such policyholder for support and maintenance, not
2 so terminate while the policy remains in force and the dependent
3 remains in such condition, if the policyholder has within 31 days of
4 such dependent's attainment of the limiting age submitted proof of
5 such dependent's incapacity as described herein. The foregoing
6 provisions of this paragraph shall not require an insurer to insure a
7 dependent who is a child with an intellectual disability or physical
8 handicap where the policy is underwritten on evidence of
9 insurability based on health factors set forth in the application or
10 where such dependent does not satisfy the conditions of the policy
11 as to any requirement for evidence of insurability or other
12 provisions of the policy, satisfaction of which is required for
13 coverage thereunder to take effect. In any such case the terms of
14 the policy shall apply with regard to the coverage or exclusion from
15 coverage of such dependent.
16 c. Notwithstanding any provision of a policy of health
17 insurance, hereafter delivered or issued for delivery in this State,
18 whenever such policy provides for reimbursement for any
19 optometric service which is within the lawful scope of practice of a
20 duly licensed optometrist, the insured under such policy shall be
21 entitled to reimbursement for such service, whether the said service
22 is performed by a physician or duly licensed optometrist.
23 d. If any policy is issued by an insurer domiciled in this State
24 for delivery to a person residing in another state, and if the official
25 having responsibility for the administration of the insurance laws of
26 such other state shall have advised the commissioner that any such
27 policy is not subject to approval or disapproval by such official, the
28 commissioner may by ruling require that such policy meet the
29 standards set forth in subsection a. of this section and in sections
30 17B:26-3 to 17B:26-31 inclusive.
31 e. Notwithstanding any provision of a policy of health
32 insurance, hereafter delivered or issued for delivery in this State,
33 whenever such policy provides for reimbursement for any
34 psychological service which is within the lawful scope of practice
35 of a duly licensed psychologist, the insured under such policy shall
36 be entitled to reimbursement for such service, whether the said
37 service is performed by a physician or duly licensed psychologist.
38 f. Notwithstanding any provision of a policy of health
39 insurance, hereafter delivered or issued for delivery in this State,
40 whenever such policy provides for reimbursement for any service
41 which is within the lawful scope of practice of a duly licensed
42 chiropractor, the insured under such policy or the chiropractor
43 rendering such service shall be entitled to reimbursement for such
44 service, when the said service is performed by a chiropractor. The
45 foregoing provision shall be liberally construed in favor of
46 reimbursement of chiropractors.
47 g. All individual health insurance policies which provide
48 coverage for a family member or dependent of the insured on an

1 expense incurred basis shall also provide that the health insurance
2 benefits applicable for children shall be payable with respect to a
3 newly born child of that insured from the moment of birth.
4 (1) The coverage for newly born children shall consist of
5 coverage of injury or sickness including the necessary care and
6 treatment of medically diagnosed congenital defects and birth
7 abnormalities.
8 (2) If payment of a specific premium is required to provide
9 coverage for a child, the policy may require that notification of
10 birth of a newly born child and payment of the required premium
11 must be furnished to the insurer within 【31】 91 days after the date
12 of birth in order to have the coverage continue beyond such 【31】
13 91-day period.
14 h. All individual health insurance policies which provide
15 coverage on an expense incurred basis but do not provide coverage
16 for a family member or dependent of the insured on an expense
17 incurred basis shall nevertheless provide for coverage of newborn
18 children of the insured which shall commence with the moment of
19 birth of each child and shall consist of coverage of injury or
20 sickness including the necessary care and treatment of medically
21 diagnosed congenital defects and birth abnormalities, provided
22 application therefor and payment of the required premium are made
23 to the insurer to include in said policy coverage the same or similar
24 to that of the insured, described in g. (1) above 【31】 91 days from
25 the date of a newborn child.
26 i. Whenever, pursuant to the provisions of an individual or
27 group contract issued by an insurer, the former spouse of a named
28 insured is no longer entitled to coverage as an individual dependent
29 by reason of divorce, separate coverage for such former spouse
30 shall be made available by the insurer on an individual non-group
31 basis under the following conditions:
32 (1) Application for such non-group coverage shall be made to
33 the insurer by or on behalf of such former spouse no later than 31
34 days following the date his or her coverage under the prior
35 certificate or contract terminated.
36 (2) No new evidence of insurability shall be required in
37 connection with the application for such non-group coverage but
38 any health exception, limitation or exclusion applicable to said
39 former spouse under the prior coverage may, at the option of the
40 insurer, be carried over to the new non-group coverage.
41 (3) The effective date of the new coverage shall be the day
42 following the date on which such former spouse's coverage under
43 the prior certificate or contract terminated.
44 (4) The benefits provided under the non-group coverage issued
45 to such former spouse shall be at least equal to the basic benefits
46 provided in contracts then being issued by the insurer to acceptable
47 new non-group applicants of the same age and family status.
48 (cf: P.L.2010, c.50, s.9)

8. N.J.S.17B:27-30 is amended to read as follows:

17B:27-30. Benefits of group health insurance, except benefits for loss of time on account of disability, may be provided for one or more members of the families or one or more dependents of persons who may be insured under a group policy referred to in section 17B:27-27, 17B:27-28 or 17B:27-29. Any group health insurance policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group must, subject to payment of the appropriate premium, permit such family members or dependents to have coverage continued for at least 180 days after the death of the person in the insured group, subject to the policy provision as to termination of coverage with respect to family members or dependents for reasons other than the death of the person in the insured group.

All group health insurance policies which provide coverage for a family member or dependent of an insured on an expense incurred basis shall also provide that the benefits applicable for children shall be payable with respect to a newly-born child of that insured from the moment of birth. The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly-born child and payment of the required premium must be furnished to the insurer within [31] 91 days after the date of birth in order to have the coverage continue beyond such [31] 91-day period.

All group health insurance policies which provide coverage on an expense incurred basis for the insured but do not provide coverage for a family member or dependent of the insured on an expense incurred basis, except such group policies as provide no dependent coverage whatsoever for the insured's class, shall nevertheless provide for coverage of newborn children of the insured which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application and payment of the required premium are made to the insurer to include in said policy coverage for a newly-born child as described in the previous paragraph of this section within [31] 91 days from the date of birth of a newborn child.

A policy under which coverage of a dependent of an employee or other member of the insured group terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical

handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such employee or member for support and maintenance, not so terminate while the insurance of the employee or member remains in force and the dependent remains in such condition, if the insured employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provision of this paragraph shall not require an insurer to insure a dependent who is a child with an intellectual disability or physical handicap of an employee or other member of the insured group where such dependent does not satisfy the conditions of the group policy as to any requirements for evidence of insurability or other provisions as may be stated in the group policy required for coverage thereunder to take effect. In any such case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent.
(cf: P.L.2010, c.50, s.10)

9. Section 16 of P.L.1997, c.146 (C.17B:27-56) is amended to read as follows:

16. A health insurer which offers a group health plan shall not impose a preexisting condition exclusion for the following: a. on a newborn child who, as of the last day of the 【30】 90-day period beginning with the date of birth, is covered under creditable coverage; b. on 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 adoption or placement for adoption, is covered under creditable coverage. These provisions shall not apply to a newborn child or child who is adopted or placed for adoption after the end of the first 63-day period, during all of which the newborn child or child who is adopted or placed for adoption was not covered under any creditable coverage; or c. pregnancy as a preexisting condition.
(cf: P.L.1997, c.146, s.16)

10. 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.

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] 90-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.

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

11. This act shall take effect immediately.

STATEMENT

This bill will extend the time period in which newly born children are covered under their parent's health benefits coverage from the current 30 days to 90 days. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless

1 the parents enroll the child in a private health benefits coverage
2 policy or in a State or federal program, such as FamilyCare.
3 The 30 day deadline can be problematic for some parents to meet
4 and may cause an unnecessary stress on the parents. This bill will
5 provide a longer period of time for children to be covered under
6 their parents' health benefits coverage which will assist new parents
7 and ensure that children have access to adequate health care during
8 the critical first few months of life.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 837

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 4, 2017

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 837.

This bill, as amended, will extend the time period in which newly born children are covered under their parent's health benefits coverage from the current 30 days to 90 days. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as FamilyCare.

The 30 day deadline can be problematic for some parents to meet and may cause an unnecessary stress on the parents. This bill will provide a longer period of time for children to be covered under their parents' health benefits coverage which will assist new parents and ensure that children have access to adequate health care during the critical first few months of life.

This bill was pre-filed for introduction in the 2016-2017 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

As amended and reported by the committee, the bill is identical to Assembly Bill No. 2665, as also amended and reported by the committee.

Committee Amendments:

The committee amendments reduce the time period in which a parent's health benefits can be extended to cover a newborn child from 90 days to 60 days, according to the parent's health benefits coverage.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 837

STATE OF NEW JERSEY

DATED: DECEMBER 14, 2017

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 837 (1R).

This bill extend the time period in which newly born children are covered under their parent's health benefits coverage from the current 30 days to 90 days. Current law limits the coverage of newly born children to 30 days from their birth. At the conclusion of 30 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as FamilyCare.

The 30 day deadline can be problematic for some parents to meet and may cause an unnecessary stress on the parents. This bill will provide a longer period of time for children to be covered under their parents' health benefits coverage which will assist new parents and ensure that children have access to adequate health care during the critical first few months of life.

As reported, the bill is identical to Assembly Bill No. 2665 (1R), as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill could potentially result in some costs shifting to private insurance that would otherwise be borne by the State's Medicaid, NJ FamilyCare, Charity Care, or Early Intervention System programs. The OLS is not able to estimate the fiscal impact of the bill with reasonable certainty, due to a lack of sufficient data. The bill would apply only to private health insurance policies regulated by the Department of Banking and Insurance, which do not track data on the number of births covered under these policies.

If the federal government determines that the extended coverage provided by the bill establishes a new mandated health benefit, the State would be required to pay for increased costs for this coverage provided under policies sold through the health insurance exchange established under the Affordable Care Act.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 837

STATE OF NEW JERSEY
217th LEGISLATURE

DATED: DECEMBER 18, 2017

SUMMARY

Synopsis: Extends health benefits coverage of a newborn infant.

Type of Impact: A possible net increase or decrease in State expenditures from the General Fund.

Agencies Affected: Department of Banking and Insurance; Department of Human Services; Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	Years 1-3
State Cost	Possible change of indeterminate direction or size – See comments below

- The bill could potentially result in some costs shifting to private insurance that would otherwise be borne by the State's Medicaid, NJ FamilyCare, Charity Care, or Early Intervention System programs.

- If the federal government determines that the extended coverage provided by the bill establishes a new mandated health benefit, the State would be required to pay for increased costs for this coverage provided under policies sold through the health insurance exchange established under the Affordable Care Act.

- The Office of Legislative Services (OLS) does not have access to data on the number of newly born children likely to be affected by the bill, or on the cost or quantity of medical services that might be shifted from the State to private payers or vice-versa.

BILL DESCRIPTION

Senate Bill No. 837 (1R) of 2016 extends the time period in which newly born children are covered under their parents' health benefits coverage to 60 days after birth. Current law limits the coverage of newly born children to 31 days from their birth. At the conclusion of 31 days, the child will be without coverage, unless the parents enroll the child in a private health benefits coverage policy or in a State or federal program, such as Medicaid or NJ FamilyCare.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS is not able to estimate the fiscal impact of the bill with reasonable certainty, due to a lack of sufficient data. In general, the bill might shift some costs related to care provided to newborns aged 31-60 days to private insurance, which would otherwise have been paid for by State-funded programs that provide care to newborn children, such as Medicaid and NJ FamilyCare, administered by the Department of Human Services. To provide an approximation of the cost of care that might be shifted to private insurance, it is noted that the Medicaid program spends approximately $2,700 per year for medical coverage for children (of which 50 percent or more is paid with the federal matching funds, depending on the specific part of the program in which the child is enrolled). Other programs that may be affected include Charity Care and the Early Intervention System, administered by the Department of Health. Data is not available on the spending in these programs related to care for newborns aged 31-60 days, but that spending would not necessarily be replaced by private insurance if the bill were enacted.

The OLS notes that approximately 103,000 live births occurred in New Jersey in 2014. According to the New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), approximately 61 percent of births in 2014 were covered by private insurance; 35 percent were covered by NJ FamilyCare (Medicaid); and 5 percent were uninsured at the time of birth. The bill would only apply to a subset of privately insured individuals, as the bill would not apply to self-insured health coverage plans or government employee or retiree health benefits plans. No data is available to the OLS on the number of births covered by such plans. Among the newborns whose mothers are enrolled in plans affected by the bill, only those who incur costs that would affect a State program would affect State costs, so households whose children are promptly enrolled in a family insurance policy generally would not be affected by the bill.

It is also noted that section 1311 of the federal Affordable Care Act includes a provision (compiled at 42 U.S.C. 18031(d)(3)(B)) allowing states to impose new health insurance benefit mandates on plans sold in the health insurance exchanges; however, in such a case the law requires the State to make payments to either the individual enrolled in the plan or the qualified health plan to defray the additional costs of this coverage. The OLS does not have data on the costs that might be incurred by the State to comply with this requirement, or the administrative costs to establish and implement a system to calculate and make such payments.

Section: *Human Services*

Analyst: *David Drescher*
Senior Fiscal Analyst

Approved: *Frank W. Haines III*
Legislative Budget and Finance Officer

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).