# 26:2S-34; Sec.7 Repealer
# LEGISLATIVE HISTORY CHECKLIST

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**LAWS OF**: 2019 **CHAPTER:** 353

**NJSA:** 26:2S-34; Sec.7 Repealer (Clarifies prohibition on preexisting condition exclusions in health insurance policies.)

**BILL NO**: S626 (Substituted for A1733)

**SPONSOR(S)** Joseph F. Vitale and others

**DATE INTRODUCED:** 1/9/2018

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

**SENATE:** Commerce
Budget & Appropriations

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:** **ASSEMBLY:** 1/13/2020

**SENATE:** 1/9/2020

**DATE OF APPROVAL:** 1/16/2020

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

**FINAL TEXT OF BILL** (Second Reprint enacted) Yes

**S626**

**SPONSOR'S STATEMENT:** (Begins on page 8 of introduced bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: No

**SENATE:** Yes Commerce
Budget & Appro.

(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:** No

**A1733**

**SPONSOR'S STATEMENT:** (Begins on page 8 of introduced bill) Yes

| | | | |
|---|---|---|---|
| **COMMITTEE STATEMENT:** | **ASSEMBLY**: | Yes | Financial Institutions & Insurance |
| | **SENATE:** | No | |

(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:** | Yes | 2/25/2019<br>1/13/2020 |
| **LEGISLATIVE FISCAL ESTIMATE:** | No | |
| **VETO MESSAGE:** | No | |
| **GOVERNOR'S PRESS RELEASE ON SIGNING:** | Yes | |

**FOLLOWING WERE PRINTED:**

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org

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|---|---|
| **REPORTS:** | No |
| **HEARINGS:** | No |
| **NEWSPAPER ARTICLES:** | Yes |

"Gov. signs bills protecting Obamacare benefits," The Times, January 21, 2020
"Murphy signs legislation protecting ACA in NJ." NJBIZ (New Brunswick, NJ), January 16, 2020.

Rwh/cl

§6 - C.26:2S-34
§7 - Repealer

P.L. 2019, CHAPTER 353, ***approved January 16, 2020***
Senate, No. 626 ***(Second Reprint)***

**AN ACT** concerning health insurance [1][and],[1] revising various parts of the statutory law [1]and supplementing P.L.1997, c.192 (C.26:2S-1 et al.)[1].

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

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

a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group [if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured]. A hospital service corporation shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

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

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

**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**
**Matter enclosed in superscript numerals has been adopted as follows:**
**[1]Senate SCM committee amendments adopted June 3, 2019.**
**[2]Senate SBA committee amendments adopted January 6, 2020.**

1 and (2) the corporation paid benefits for the condition under the
2 group contract in which the person was previously insured]. A
3 medical service corporation shall not include a preexisting
4 condition as a factor in calculating the premium.
5 b. Nothing in this section shall be construed to operate to add
6 any benefit, to increase the scope of any benefit, or to increase any
7 benefit level under any group contract.
8 c. This section shall apply to every group contract or policy in
9 which the corporation or insurer has the right to change the
10 premium.
11 (cf: P.L.1989, c.63, s.1)
12
13 3. Section 3 of P.L.1989, c.63 (C.17:48E-35.2) is amended to
14 read as follows:
15 a. Notwithstanding any other provision of law to the contrary,
16 no group health insurance contract issued by a health service
17 corporation pursuant to the provisions of P.L.1985, c.236
18 (C.17:48E-1 et seq.), shall contain any provision which denies
19 benefits for a preexisting condition to any person becoming a
20 member of that group [if: (1) during the period immediately
21 preceding the person's becoming a member of the group the person
22 was enrolled as a member under another group contract issued by
23 the corporation; and (2) the corporation paid benefits for the
24 condition under the group contract in which the person was
25 previously insured]. A health service corporation shall not include
26 a preexisting condition as a factor in calculating the premium.
27 b. Nothing in this section shall be construed to operate to add
28 any benefit, to increase the scope of any benefit, or to increase any
29 benefit level under any group contract.
30 c. This section shall apply to every group contract or policy in
31 which the corporation or insurer has the right to change the
32 premium.
33 (cf: P.L.1989, c.63, s.3)
34
35 [1][4. Section 15 of P.L.1997, c.146 (C.17B:27-55) is amended
36 to read as follows:
37 15. A health insurer [may] shall not impose a preexisting
38 condition exclusion in its group health plan [only if:
39 a. the exclusion relates to a physical or mental condition for
40 which medical advice, diagnosis, care or treatment was
41 recommended or received within the six-month period ending on
42 the enrollment date of the participant or beneficiary;
43 b. the exclusion extends for a period of not more than 12
44 months, or 18 months for a late enrollee, after the enrollment date
45 of the participant or beneficiary; and
46 c. the period of any preexisting condition exclusion is reduced
47 by the aggregate of the periods of creditable coverage applicable to

the participant or beneficiary as of the enrollment date] and shall not include a preexisting condition as a factor in calculating the premium.
(cf: P.L.1997, c.146, s.15)][1]

[1][5.] 4.[1] Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read as follows:

6. The commissioner shall approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The commissioner shall provide the board with an informational filing of the policy and contract forms and benefit levels it approves.

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

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

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

(2) to a federally defined eligible individual who applies for an individual health benefits plan within 63 days of termination of the prior coverage] and shall not include a preexisting condition as a factor in calculating the premium.

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

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

1 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),
2 a deductible shall not be applied for any benefits provided pursuant
3 to this subsection that represent preventive care as permitted by that
4 federal law, and shall not be applied as provided pursuant to section
5 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall
6 apply to all individual health benefits plans in which the carrier has
7 reserved the right to change the premium.
8 f. Effective immediately for a health benefits plan issued on or
9 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
10 effective on the first 12-month anniversary date of a health benefits
11 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
12 et al.), the health benefits plans required pursuant to section 3 of
13 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses
14 incurred in the purchase of prescription drugs shall provide benefits
15 for expenses incurred in the purchase of specialized non-standard
16 infant formulas, when the covered infant's physician has diagnosed
17 the infant as having multiple food protein intolerance and has
18 determined such formula to be medically necessary, and when the
19 covered infant has not been responsive to trials of standard non-cow
20 milk-based formulas, including soybean and goat milk. The
21 coverage may be subject to utilization review, including periodic
22 review, of the continued medical necessity of the specialized infant
23 formula.
24 The benefits shall be provided to the same extent as for any other
25 prescribed items under the health benefits plan.
26 This subsection shall apply to all individual health benefits plans
27 in which the carrier has reserved the right to change the premium.
28 g. Effective immediately for an individual health benefits plan
29 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
30 35.27 et al.) and effective on the first 12-month anniversary date of
31 an individual health benefits plan in effect on the effective date of
32 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
33 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)
34 that qualify as high deductible health plans for which qualified
35 medical expenses are paid using a health savings account
36 established pursuant to section 223 of the federal Internal Revenue
37 Code of 1986 (26 U.S.C. s.223), including any plan offered by a
38 federally qualified health maintenance organization, shall contain
39 benefits for expenses incurred in connection with any medically
40 necessary benefits provided in-network which represent preventive
41 care as permitted by that federal law.
42 The benefits provided pursuant to this subsection shall be
43 provided to the same extent as for any other medical condition
44 under the health benefits plan, except that a deductible shall not be
45 applied for benefits provided pursuant to this subsection. This
46 subsection shall apply to all individual health benefits plans in
47 which the carrier has reserved the right to change the premium.
48 (cf: P.L.2012, c.17, s.57)

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

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

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

(1)] shall be subject to the same rating requirements that apply to health benefits plans issued pursuant to paragraph (2) of subsection a. of section 9 of P.L.1992, c.162 (C.17B:27A-25), except that a hospital confinement plan and supplemental limited benefit insurance plan shall be subject to the commissioner's exclusive review and regulation with regard to loss ratios, medical underwriting and eligibility requirements, and form approval[; and

(2) may include preexisting condition exclusions].

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

(cf: P.L.1994, c.11, s.10)][1]

[1][7.] 5.[1] 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 [2][include a preexisting condition as a factor in calculating the premium or][2] include any provision excluding coverage for a preexisting condition regardless of the cause of the condition [, provided that a preexisting condition provision may apply to a late enrollee or to any group of two to five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of such enrollee and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee].

b. [In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under creditable coverage if the creditable coverage was continuous to a date not

more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan. A carrier shall provide credit pursuant to this provision in one of the following methods:

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

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

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

(1) A newborn child who, as of the last date of the 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.] (Deleted by amendment, P.L. , c. ) (pending before the Legislature as this bill)

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

[1]6. (New section) A carrier that offers a health benefits plan in this State shall ensure that the plan does not contain any provision [2][which] that:

a.[2] denies [2]or limits[2] benefits for a preexisting condition to any covered person [2]; or

b. uses a preexisting condition as a factor in calculating a premium[2].[1]

[1][8.] 7.[1] Sections [1][16] 15[1] through 19 of P.L.1997, c.146 [1][(C.17B:27-56] (C.17B:27-55[1] through 17B:27-59) are repealed.

[1][9.] 8.[1] This act shall take effect immediately.

1 ---
2
3 Clarifies prohibition on preexisting condition exclusions in
4 health insurance policies.

# SENATE, No. 626

# STATE OF NEW JERSEY

## 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

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

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

**SYNOPSIS**
Clarifies prohibition on preexisting condition exclusions in health insurance policies.

**CURRENT VERSION OF TEXT**
Introduced Pending Technical Review by Legislative Counsel.

**(Sponsorship Updated As Of: 5/28/2019)**

1 **AN ACT** concerning health insurance and revising various parts of
2 the statutory law.
3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*
6
7 1. Section 2 of P.L.1989, c.63 (C.17:48-6e) is amended to read
8 as follows:
9 a. Notwithstanding any other provision of law to the contrary,
10 no group health insurance contract issued by a hospital service
11 corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-
12 1 et seq.), shall contain any provision which denies benefits for a
13 preexisting condition to any person becoming a member of that
14 group **[**if: (1) during the period immediately preceding the person's
15 becoming a member of the group the person was enrolled as a
16 member under another group contract issued by the corporation;
17 and (2) the corporation paid benefits for the condition under the
18 group contract in which the person was previously insured**]**. A
19 hospital service corporation shall not include a preexisting
20 condition as a factor in calculating the premium.
21 b. Nothing in this section shall be construed to operate to add
22 any benefit, to increase the scope of any benefit, or to increase any
23 benefit level under any group contract.
24 c. This section shall apply to every group contract or policy in
25 which the corporation or insurer has the right to change the
26 premium.
27 (cf: P.L.1989, c.63, s.2)
28
29 2. Section 1 of P.L.1989, c.63 (C.17:48A-7d) is amended to
30 read as follows:
31 a. Notwithstanding any other provision of law to the contrary,
32 no group health insurance contract issued by a medical service
33 corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-
34 1 et seq.), shall contain any provision which denies benefits for a
35 preexisting condition to any person becoming a member of that
36 group **[**if: (1) during the period immediately preceding the person's
37 becoming a member of the group the person was enrolled as a
38 member under another group contract issued by the corporation;
39 and (2) the corporation paid benefits for the condition under the
40 group contract in which the person was previously insured**]**. A
41 medical service corporation shall not include a preexisting
42 condition as a factor in calculating the premium.
43 b. Nothing in this section shall be construed to operate to add
44 any benefit, to increase the scope of any benefit, or to increase any
45 benefit level under any group contract.

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

**Matter underlined thus is new matter.**

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

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

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

a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a health service corporation pursuant to the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group [if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured]. A health service corporation shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

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

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

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

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

c. the period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date] and shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

the commissioner of the certification, the certified plans may be used until the commissioner, after notice and hearing, disapproves their continued use.

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

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

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

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

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

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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

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

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

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

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

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

10. a. A carrier shall not deliver or issue for delivery a hospital confinement or other supplemental limited benefit insurance plan unless the applicant for such coverage signs a statement on the application form that confirms that the applicant is already covered

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

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

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

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

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

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

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

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

9. This act shall take effect immediately.

STATEMENT

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

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

# SENATE COMMERCE COMMITTEE

## STATEMENT TO

# SENATE, No. 626

with committee amendments

# STATE OF NEW JERSEY

DATED: JUNE 3, 2019

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 626.

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

As amended, the bill also supplements the "Health Care Quality Act" to clarify that health insurance carriers offering any health benefits plans in the State cannot exclude coverage in those plans for any covered person for a preexisting condition.

This bill provides that the prohibition on insurers excluding coverage for preexisting conditions, putting certain waiting periods on coverage, or using a preexisting condition as a factor in setting premiums, would continue to be prohibited in New Jersey, if the Affordable Care Act is ever amended or repealed.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

Committee Amendments:

The committee amendments, by repealing certain statutes relating to group health insurance plans, and by inserting a new section of law into the "Health Care Quality Act," clarify that health insurance carriers offering any health benefits plans in the State cannot exclude coverage in those plans for any covered person for a preexisting condition.

# SENATE BUDGET AND APPROPRIATIONS COMMITTEE

## STATEMENT TO

## [First Reprint]
## SENATE, No. 626

with committee amendments

# STATE OF NEW JERSEY

DATED: JANUARY 6, 2020

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 626 (1R), with committee amendments.

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

The bill supplements the "Health Care Quality Act" to clarify that health insurance carriers offering any health benefits plans in the State may not deny or limit benefits for a preexisting condition or use a preexisting condition as a factor in calculating a premium.

This bill provides that the prohibition on insurers excluding coverage for preexisting conditions, putting certain waiting periods on coverage, or using a preexisting condition as a factor in setting premiums, would continue to be prohibited in New Jersey, if the Affordable Care Act is ever amended or repealed.

COMMITTEE AMENDMENTS:

The committee amendments add a requirement to the "Health Care Quality Act" to provide that health insurance carriers offering health benefits plans in the State cannot use a preexisting condition as a factor in calculating a premium.

The committee amendments also remove a provision from the bill that prohibited health benefits plans under the New Jersey Small

Employer Health Benefits Program from including a preexisting condition as a factor in calculating a premium, because those plans are prohibited from using preexisting conditions under existing law.

FISCAL IMPACT:

This bill is not certified as requiring a fiscal note.

# ASSEMBLY, No. 1733

# STATE OF NEW JERSEY

## 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

**Sponsored by:**
**Assemblywoman VALERIE VAINIERI HUTTLE**
**District 37 (Bergen)**
**Assemblyman NICHOLAS CHIARAVALLOTI**
**District 31 (Hudson)**
**Assemblywoman JOANN DOWNEY**
**District 11 (Monmouth)**
**Assemblyman JOE DANIELSEN**
**District 17 (Middlesex and Somerset)**

**Co-Sponsored by:**
**Assemblyman Johnson, Assemblywoman Murphy and Assemblyman McKeon**

**SYNOPSIS**
Clarifies prohibition on preexisting condition exclusions in health insurance policies.

**CURRENT VERSION OF TEXT**
Introduced Pending Technical Review by Legislative Counsel.

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

1 **AN ACT** concerning health insurance and revising various parts of
2 the statutory law.
3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*
6
7 1. Section 2 of P.L.1989, c.63 (C.17:48-6e) is amended to read
8 as follows:
9 a. Notwithstanding any other provision of law to the contrary,
10 no group health insurance contract issued by a hospital service
11 corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-
12 1 et seq.), shall contain any provision which denies benefits for a
13 preexisting condition to any person becoming a member of that
14 group **[**if: (1) during the period immediately preceding the person's
15 becoming a member of the group the person was enrolled as a
16 member under another group contract issued by the corporation;
17 and (2) the corporation paid benefits for the condition under the
18 group contract in which the person was previously insured**]**.
19 b. Nothing in this section shall be construed to operate to add
20 any benefit, to increase the scope of any benefit, or to increase any
21 benefit level under any group contract.
22 c. This section shall apply to every group contract or policy in
23 which the corporation or insurer has the right to change the
24 premium.
25 (cf: P.L.1989, c.63, s.2)
26
27 2. Section 1 of P.L.1989, c.63 (C.17:48A-7d) is amended to
28 read as follows:
29 a. Notwithstanding any other provision of law to the contrary,
30 no group health insurance contract issued by a medical service
31 corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-
32 1 et seq.), shall contain any provision which denies benefits for a
33 preexisting condition to any person becoming a member of that
34 group **[**if: (1) during the period immediately preceding the person's
35 becoming a member of the group the person was enrolled as a
36 member under another group contract issued by the corporation;
37 and (2) the corporation paid benefits for the condition under the
38 group contract in which the person was previously insured**]**.
39 b. Nothing in this section shall be construed to operate to add
40 any benefit, to increase the scope of any benefit, or to increase any
41 benefit level under any group contract.
42 c. This section shall apply to every group contract or policy in
43 which the corporation or insurer has the right to change the
44 premium.
45 (cf: P.L.1989, c.63, s.1)

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

**Matter underlined thus is new matter.**

1 3. Section 3 of P.L.1989, c.63 (C.17:48E-35.2) is amended to
2 read as follows:
3 a. Notwithstanding any other provision of law to the contrary,
4 no group health insurance contract issued by a health service
5 corporation pursuant to the provisions of P.L.1985, c.236
6 (C.17:48E-1 et seq.), shall contain any provision which denies
7 benefits for a preexisting condition to any person becoming a
8 member of that group [if: (1) during the period immediately
9 preceding the person's becoming a member of the group the person
10 was enrolled as a member under another group contract issued by
11 the corporation; and (2) the corporation paid benefits for the
12 condition under the group contract in which the person was
13 previously insured].
14 b. Nothing in this section shall be construed to operate to add
15 any benefit, to increase the scope of any benefit, or to increase any
16 benefit level under any group contract.
17 c. This section shall apply to every group contract or policy in
18 which the corporation or insurer has the right to change the
19 premium.
20 (cf: P.L.1989, c.63, s.3)
21
22 4. Section 15 of P.L.1997, c.146 (C.17B:27-55) is amended to
23 read as follows:
24 15. A health insurer [may] <u>shall not</u> impose a preexisting
25 condition exclusion in its group health plan [only if:
26 a. the exclusion relates to a physical or mental condition for
27 which medical advice, diagnosis, care or treatment was
28 recommended or received within the six-month period ending on
29 the enrollment date of the participant or beneficiary;
30 b. the exclusion extends for a period of not more than 12
31 months, or 18 months for a late enrollee, after the enrollment date
32 of the participant or beneficiary; and
33 c. the period of any preexisting condition exclusion is reduced
34 by the aggregate of the periods of creditable coverage applicable to
35 the participant or beneficiary as of the enrollment date].
36 (cf: P.L.1997, c.146, s.15)
37
38 5. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
39 read as follows:
40 6. The commissioner shall approve the policy and contract
41 forms and benefit levels to be made available by all carriers for the
42 health benefits plans required to be issued pursuant to section 3 of
43 P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications
44 to one or more plans as the board determines are necessary to make
45 available a "high deductible health plan" or plans consistent with
46 section 301 of Title III of the "Health Insurance Portability and
47 Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),

1 regarding tax-deductible medical savings accounts, within 60 days
2 after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The
3 commissioner shall provide the board with an informational filing
4 of the policy and contract forms and benefit levels it approves.
5 a. The individual health benefits plans established by the board
6 may include cost containment measures such as, but not limited to:
7 utilization review of health care services, including review of
8 medical necessity of hospital and physician services; case
9 management benefit alternatives; selective contracting with
10 hospitals, physicians, and other health care providers; and
11 reasonable benefit differentials applicable to participating and
12 nonparticipating providers; and other managed care provisions.
13 b. ⟦An individual health benefits plan offered pursuant to
14 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a
15 limitation of no more than 12 months on coverage for preexisting
16 conditions.⟧ An individual health benefits plan offered pursuant to
17 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a
18 preexisting condition limitation of any period ⟦under the following
19 circumstances:
20 (1) to an individual who has, under creditable coverage, with no
21 intervening lapse in coverage of more than 31 days, been treated or
22 diagnosed by a physician for a condition under that plan or satisfied
23 a 12-month preexisting condition limitation; or
24 (2) to a federally defined eligible individual who applies for an
25 individual health benefits plan within 63 days of termination of the
26 prior coverage⟧.
27 c. In addition to the standard individual health benefits plans
28 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the
29 board may develop up to five rider packages. Premium rates for the
30 rider packages shall be determined in accordance with section 8 of
31 P.L.1992, c.161 (C.17B:27A-9).
32 d. After the board's establishment of the individual health
33 benefits plans required pursuant to section 3 of P.L.1992, c.161
34 (C.17B:27A-4), and notwithstanding any law to the contrary, a
35 carrier shall file the policy or contract forms with the commissioner
36 and certify to the commissioner that the health benefits plans to be
37 used by the carrier are in substantial compliance with the provisions
38 in the corresponding approved plans. The certification shall be
39 signed by the chief executive officer of the carrier. Upon receipt by
40 the commissioner of the certification, the certified plans may be
41 used until the commissioner, after notice and hearing, disapproves
42 their continued use.
43 e. Effective immediately for an individual health benefits plan
44 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
45 35.27 et al.) and effective on the first 12-month anniversary date of
46 an individual health benefits plan in effect on the effective date of
47 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health
48 benefits plans required pursuant to section 3 of P.L.1992, c.161

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

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

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

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

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

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

1 determined such formula to be medically necessary, and when the
2 covered infant has not been responsive to trials of standard non-cow
3 milk-based formulas, including soybean and goat milk. The
4 coverage may be subject to utilization review, including periodic
5 review, of the continued medical necessity of the specialized infant
6 formula.
7 The benefits shall be provided to the same extent as for any other
8 prescribed items under the health benefits plan.
9 This subsection shall apply to all individual health benefits plans
10 in which the carrier has reserved the right to change the premium.
11 g. Effective immediately for an individual health benefits plan
12 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
13 35.27 et al.) and effective on the first 12-month anniversary date of
14 an individual health benefits plan in effect on the effective date of
15 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
16 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)
17 that qualify as high deductible health plans for which qualified
18 medical expenses are paid using a health savings account
19 established pursuant to section 223 of the federal Internal Revenue
20 Code of 1986 (26 U.S.C. s.223), including any plan offered by a
21 federally qualified health maintenance organization, shall contain
22 benefits for expenses incurred in connection with any medically
23 necessary benefits provided in-network which represent preventive
24 care as permitted by that federal law.
25 The benefits provided pursuant to this subsection shall be
26 provided to the same extent as for any other medical condition
27 under the health benefits plan, except that a deductible shall not be
28 applied for benefits provided pursuant to this subsection. This
29 subsection shall apply to all individual health benefits plans in
30 which the carrier has reserved the right to change the premium.
31 (cf: P.L.2012, c.17, s.57)
32
33 6. Section 10 of P.L.1994, c.11 (C.17B:27A-19.1) is amended
34 to read as follows:
35 10. a. A carrier shall not deliver or issue for delivery a hospital
36 confinement or other supplemental limited benefit insurance plan
37 unless the applicant for such coverage signs a statement on the
38 application form that confirms that the applicant is already covered
39 under a health benefits plan contract or policy. The application
40 form shall be filed with the board on an informational basis.
41 b. A hospital confinement plan or other supplemental limited
42 benefit insurance plan issued to a small employer or other group
43 health benefits plan provider or to individual employees of a small
44 employer or other group health benefits provider **[**:
45 (1)**]** shall be subject to the same rating requirements that apply
46 to health benefits plans issued pursuant to paragraph (2) of
47 subsection a. of section 9 of P.L.1992, c.162 (C.17B:27A-25),
48 except that a hospital confinement plan and supplemental limited

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

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

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

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

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

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

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

9. This act shall take effect immediately.

STATEMENT

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

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

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 1733

# STATE OF NEW JERSEY

DATED: JANUARY 28, 2019

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 1733.

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

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

# STATEMENT TO

# ASSEMBLY, No. 1733

with Assembly Floor Amendments
(Proposed by Assemblywoman VAINIERI HUTTLE)

ADOPTED: FEBRUARY 25, 2019

These amendments allow health insurance carriers to continue to offer hospital confinement or other supplemental limited benefit insurance plans that include preexisting condition exclusions.

While the bill generally prohibits health benefits plans from excluding coverage for preexisting conditions in conformance with the Affordable Care Act, hospital confinement and other supplemental limited benefit plans are structured differently than health benefits plans. Accordingly, these amendments, by omitting section 6 from the bill, retain current New Jersey law concerning employer provided hospital confinement and other supplemental limited benefit plans, which allows these plans to include preexisting condition exclusions.

STATEMENT TO

[First Reprint]

# ASSEMBLY, No. 1733

with Assembly Floor Amendments
(Proposed by Assemblywoman VAINIERI HUTTLE)

ADOPTED: JANUARY 13, 2020

These Assembly amendments add a requirement to the "Health Care Quality Act" to provide that a health insurance carrier that offers a health benefits plan in this State must ensure that the plan does not contain any provision that denies or limits benefits for a preexisting condition to any covered person.

The amendments also add a requirement to the "Health Care Quality Act," and revise other parts of the statutory law, to provide that health insurance carriers may not use a preexisting condition as a factor in calculating a premium.

# Governor Murphy Signs Legislative Package Protecting the Affordable Care Act in New Jersey

01/16/2020

**TRENTON –** Governor Phil Murphy today signed a package of bills to safeguard the provisions of the Affordable Care Act (ACA) in New Jersey. The bills, which will codify into state law the basic protections for health care consumers that are part of the Affordable Care Act, include protections for no-cost preventative care and contraception, prohibit exclusions for pre-existing conditions, allow children to stay on their parents' plan until age 26, and incorporate mental health and maternity care as part of essential benefits, among others. The Governor highlighted the importance of these bills during an armchair discussion with Hackensack Meridian Health Chief Executive Officer Bob Garret.

"At a time when the Affordable Care Act is under siege by the Trump Administration and being challenged in the courts, New Jersey has a responsibility to protect and provide access to high-quality, affordable health care for all of our residents," **said Governor Murphy.** "I applaud my colleagues in the Legislature for taking the critical steps necessary to ensure that the provisions of the Affordable Health Care Act are codified into state law and for working to make the health of our residents a top priority."

The Governor signed the following bills into law:

**A5500 (Greenwald, Lopez, Lampitt/Pou, Lagana)** - Expands rate review process in DOBI for certain individual and small employer health benefits plans.

**A5501 (McKeon, Vainieri Huttle, Speight/Pou, Weinberg)** - Requires continuation of health benefits dependent coverage until child turns 26 years of age.

**A5503 (Reynolds-Jackson, Swain/Vitale, Cryan)** - Establishes open enrollment period under Individual Health Coverage Program.

**A5504 (Benson, Schaer/Cryan, Diegnan)** - Applies 85 percent loss ratio requirement to certain large group health benefits carriers.

**A5506 (Tully, Danielsen/Singleton, Diegnan)** - Repeals statute authorizing offering of "Basic and Essential" health benefits plans under individual health benefits plans and other statutes concerning basic health plans; makes conforming amendments.

**A5507 (McKeon, Conaway, Mukherji/Pou, Ruiz)** - Requires health benefits coverage for certain preventive services.

**A5508 (Zwicker, Murphy, Sumter/Ruiz, Pou)** - Revises law requiring health benefits coverage for certain contraceptives.

**A5248 (Conaway, Mukherji, McKeon/Gill, Singleton)** - Preserves certain requirements that health insurance plans cover essential health benefits.

**S626 (Vitale, Diegnan/Vainieri Huttle, Chiaravalloti, Downey, Danielsen) -** Clarifies prohibition on preexisting condition exclusions in health insurance policies.

"It is more than health insurance, it is security. It is the safety you feel in knowing that if something goes wrong you have somewhere to go," **said Senator Pou.** "While not every New Jerseyan has health insurance coverage, there are a lot more people covered now because of the Affordable Care Act than there were before the landmark legislation led by the Obama administration. This life-saving federal program, however, is currently being attacked by Trump and the Republicans in Congress and I am proud of the Governor and Legislature for

standing up for residents and making the ACA the law of our state, regardless of who is in the White House."

"With the President trying to do everything he can to destroy the Affordable Care Act, I'm glad the legislature and the administration worked together to ensure that the people who benefitted from the ACA will be protected in New Jersey," **said Senator Vitale**. "We cannot leave the health and safety of New Jerseyans up to the whims of the oval office. These laws, along with the state health care exchange signed earlier, will go a long way to make sure our state can offer affordable health care to all of our residents."

"The Affordable Care Act gave millions of people across the country access to health care and protected those with pre-existing conditions from being discriminated against by health insurance companies," **said Senator Singleton.**"Taking away a person's health insurance, regardless of whether or not they will be able to find an alternative, is disgraceful. New Jersey is a state that protects its residents, and by strengthening the ACA in this state, we will continue to protect working and middle class families."

"Contraception was named as one of the top ten public health achievements of the 20th century by the Centers for Disease Control and Prevention. That was twenty years ago, whether or not insurance plans cover contraceptives shouldn't be a question today," **said Senator Ruiz.** "It's a matter of public health and it's a matter of gender equity. People should have access to birth control and this law will help ensure that they do."

**A5500**

"The affordable care act has helped tens of thousands of New Jersey residents gain access to healthcare for themselves and their families," **said Assemblyman Greenwald.** "With this law, we are keeping healthcare affordable for working families by preventing unreasonable rate hikes for the insured, preserving the substantial progress we've made on increasing access to quality healthcare in New Jersey."

"The Affordable Care Act has changed the lives of many New Jersey families," **said Assemblywoman Lopez.** "Protecting families against unjustified rate changes is critical to maintaining and expanding access to healthcare in the state for many more residents."

"This is the next practical step in protecting thousands of New Jerseyans who have been afforded healthcare benefits under the Affordable Care Act," **said Assemblywoman Lampitt.** "The key is to ensure health insurance remains affordable for all residents by keeping an eye on and preventing unnecessary rate increases."

**A5501**

Assemblymembers McKeon, Vainieri Huttle, and Speight issued a joint statement:

"With many college graduates returning home while they look for jobs, there was a steep rise in residents ages 19 -26 without access to healthcare. For those who did have insurance through their parents, the cost became an additional, unexpected burden on families. The Affordable Care Act has significantly helped to reduce the uninsured rate for young adults under the age of 26 by allowing parents to cover them in their own plans without the requirement of a separate premium. Codifying this into New Jersey State law will help families ensure their children, whether they are continuing their education or at home temporarily, are provided for in terms of healthcare."

**A5503**

Assemblymembers Reynolds-Jackson and Swain issued the following statement:

"Changes on the federal level of ACA have deliberately shortened the open enrollment period by 50 percent placing consumers at a great disadvantage. There's less time to research their coverage options and enroll. As New Jersey embarks on the creation of a State-based healthcare exchange, it is critical to ensure open enrollment periods which provide enough time, promotion and access for residents."

**A5504**

"The Affordable Care Act was groundbreaking in expanding health insurance coverage for millions of Americans. It is important for our state that we maintain the essential protections of Obamacare for all our families," **said Assemblyman Benson.** "This new state law will help guarantee the money residents spend on their health insurance overwhelmingly goes to the medical care and services they need."

"This law allows for continued oversight of health insurance companies so that our state can make sure they are properly applying customers' payments," **said Assemblyman Schaer.** "There is no room for frivolous spending when it comes to health; the hard-earned money coming out of our residents' paychecks for health insurance should go towards actually giving them the treatments, tests, procedures and medications they need."

**A5507**

Assemblymembers McKeon, Conaway and Mukherji joint statement:

"Preventive healthcare is critical to helping individuals' live longer, healthier lives. In the long run, preventive medicine and services helps families' keep healthcare costs down and avoid potential health problems. These are services every resident relies on for themselves and their children. The Affordable Care Act ensured more residents' access to preventive care than before. Setting these same standards under the State-based healthcare exchange will continue to protect New Jersey families' and their access to these critical services."

**A5506**

"It's understandable that the government wanted to encourage Americans to purchase ACA health insurance by initially offering simple and inexpensive plans," **said Assemblyman Tully.** "However, we now know these 'Basic and Essential Plans' simply do not cover the healthcare services many people require, which is why the ACA no longer allows them. In case the ACA is ever dismantled at the federal level, this law will make sure providers in our state do not begin offering these limited plans again."

"Although some people were drawn to the lower-cost healthcare plans the ACA once provided, many didn't realize just how limited their coverage would be," **said Assemblyman Danielsen.** "When it comes to healthcare, the services provided can literally mean the difference between life and death. From high stakes procedures to daily medicine, no one should have to lose their life or experience crushing medical debt due to a lack of coverage. This will help make sure such restrictive plans can never be offered in the future."

**A5508**

Assemblymembers Zwicker, Murphy, and Sumter joint statement:

"Federal changes to the Affordable Care Act aimed to jeopardize women's access to safe, preventive care. This new law will remove those obstacles in New Jersey and preserve the benefits afforded to residents' under the ACA. With this law, women will continue to have insurance that covers contraception without having to pay out of pocket."

"Because of the Affordable Care Act, as many as 133 million people – or 51 percent of Americans – who have pre-existing conditions are guaranteed that condition will be covered by their health insurer," **said Assemblywoman Vainieri Huttle.** "But the ACA has been threatened in the past few years. This new law will safeguard this crucial protection for patients should anything ever happen to the ACA."

"When the ACA was passed, state law was never changed to include the mandate for coverage of pre-existing conditions," **said Assemblyman Chiaravalloti.** "This important update sends a clear message that we in New Jersey believe health care is not a privilege, but a right."

"People with pre-existing conditions had their lives changed when the Affordable Care Act became law in 2010," **said Assemblywoman Downey.** "For the first time, they could not be denied coverage by an insurance company because of their conditions, from diabetes to allergies to cancer. We cannot go back to a world where people had less access to critical medications or treatments because of poor insurance coverage. With this law, we ensure that will never happen in New Jersey."

"No one should ever be penalized for having a medical condition," **said Assemblyman Danielsen.** "The ACA paved the way for Americans to begin seeing what was possible when they had access to coverage for pre-existing conditions. So many people now have far better quality of life as a result, and that's something we will fight to protect and guarantee for all New Jersey residents."

**A5248**

"As a physician, I firmly believe that access to health care is a right, not a privilege," **said Assemblyman Conaway.** "We took a tremendous step forward toward securing that right for all Americans under the Affordable Care Act. The legislation signed today will enshrine the essential health benefits and guiding principles of the ACA into State law, so that New Jerseyans will continue receiving the same benefits if the ACA were ever struck down."

"We hear stories far too often of patients facing discrimination because of their age or disability," **said Assemblyman Mukherji.** "No one should be penalized or taken advantage for having a health condition. This is the law of the land nationwide, and we've now reaffirmed these values here in New Jersey."

"Essential health benefits are exactly that: essential," **said Assemblyman McKeon.** "Our children need vision and oral care; our new mothers need maternity care; and at any moment, anyone may need emergency services. I'm proud to live in a state that values the health and wellbeing of its residents, so much that it guarantees certain protections under the law."