LEGISLATIVE HISTORY CHECKLIST

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LAWS of 1999

CHAPTER: 49

NJSA:17:48-6U et al
(Dental procedures -- insurance)

BILL NO:A1913 (Substituted for S1265 -- 1st Reprint)

SPONSOR(S): Wisniewski and Bateman

DATE INTRODUCED: March 30, 1998

COMMITTEE:
ASSEMBLY:Banking and Insurance
SENATE:Health

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE:
ASSEMBLY:January 28, 1999
SENATE:December 17, 1998

DATE OF APPROVAL: March 12, 1999

THE FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL: *Yes*2nd Reprint
(Amendments during passage denoted by superscript numbers)

A1913

SPONSORS STATEMENT: *Yes*(Begins on page 13 of original bill)

COMMITTEE STATEMENT:
ASSEMBLY:*Yes*
SENATE:*Yes*

FLOOR AMENDMENT STATEMENTS: *No*

LEGISLATIVE FISCAL ESTIMATE: *No*

S1265

SPONSORS STATEMENT: *Yes*(Begins on page 13 of original bill)
Bill and Sponsor's Statement identical to A1913

COMMITTEE STATEMENT:

ASSEMBLY: *No*
SENATE: *Yes*
Identical to Assembly Statement for A1913

FLOOR AMENDMENT STATEMENTS:*No*

LEGISLATIVE FISCAL ESTIMATE: *No*

1st REPRINT (Final version): *Yes*

GOVERNOR'S ACTIONS

VETO MESSAGE: *No*

GOVERNOR'S PRESS RELEASE ON SIGNING: *YES*

THE FOLLOWING WERE PRINTED:

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REPORTS: *No*

HEARINGS: *No*

NEWSPAPER ARTICLES: *No*

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§1 C. 17:48-6u
§2 C. 17:48A-7t
§3 C. 17:48E-35.19
§4 C. 17B:26-2.1r
§5 C. 17B:27-46.1u
§6 C. 26:2J-4.19
§7 Note To §§1-6

P.L. 1999, CHAPTER 49, ***approved March 12, 1999***
Assembly, No. 1913 ***(Second Reprint)***

AN ACT requiring health insurance coverage for certain dental procedures [1]**[**and amending**]**[1] and supplementing various parts of the statutory law.

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

1. a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder [1]who is severely disabled or a child age five or under[1] for expenses incurred for [1]: (1)[1] general anesthesia and hospitalization for dental services [1]**[**provided to a covered person who has**]** ; or (2)[1] a medical condition [1]**[**and**]** covered by the contract which[1] requires hospitalization or general anesthesia for dental services [1]**[**; and general anesthesia and treatment**]**[1] rendered by a dentist [1]**[**for a medical condition covered by the contract**]**[1] regardless of where the [1]dental[1] services are provided.

b. A group or individual hospital service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

[2]**[**2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to read as follows:

53. a. A basic health care contract offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) shall provide:

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] Assembly ABI committee amendments adopted June 1, 1998.
[2] Senate SHH committee amendments adopted October 15, 1998.

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related [X-rays] appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a medical service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare

pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

(2) A medical service corporation shall not sell a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a medical service corporation shall file copies of all forms of contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 8 of P.L.1995, c.73 (C.17:48A-9.2), provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a medical service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum

standards for loss ratios under contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

g. Notwithstanding any provision of law to the contrary, a medical service corporation shall not be required, in regard to contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every medical service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1995, c.73, s.10)**]**[2]

[2]**[**3.**]** 2.[2] a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 [1]**[**(C.17:48-1 et seq.)**]** (C.17:48A-1 et seq.)[1], or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder [1]who is severely disabled or a child age five or under[1] for expenses incurred for [1]: (1)[1] general anesthesia and hospitalization for dental services [1]**[**provided to a covered person who has**]** ; or (2)[1] a medical condition [1]**[**and**]** covered by the contract which[1] requires hospitalization or general anesthesia for dental services [1]**[**; and general anesthesia and treatment**]**[1] rendered by a dentist [1]**[**for a medical condition covered by the contract**]**[1] regardless of where the [1]dental[1] services are provided.

b. A group or individual medical service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

[2]**[**4. Section 55 of P.L.1991, c.187 (C.17:48E-22.2) is amended to read as follows:

55. a. A basic health care contract offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and **[**X-ray**]** appropriate diagnostic imaging and **[**laboratory**]** clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related **[**X-rays**]** appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years;

and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

(2) A health service corporation shall not sell a contract required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) to a group which was covered by health benefits or health insurance any time during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of <u>Banking and</u> Insurance.

d. Notwithstanding any other law to the contrary, a health service corporation shall file copies of all forms of contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the Commissioner of <u>Banking and</u> Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to its effective date specifying in what respects the form is not in compliance with the standards set forth in this subsection, any such contract form filed with the commissioner shall be deemed approved as of its effective date, provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health service

corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum standards for loss ratios under contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

g. Notwithstanding any provision of law to the contrary, a health service corporation shall not be required, in regard to contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every health service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1991, c.187, s.55)**]**[2]

[2]**[**5.**]** 3.[2] a. No group or individual health service corporation contract providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 [1]**[**(C.17:48-1 et seq.)**]** (C.17:48E-1 et seq.)[1], or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary

act, unless the contract provides benefits to any person covered thereunder [1]who is severely disabled or a child age five or under[1] for expenses incurred for [1]: (1)[1] general anesthesia and hospitalization for dental services [1][provided to a covered person who has]; or (2)[1] a medical condition [1][and] covered by the contract which[1] requires hospitalization or general anesthesia for dental services [1][; and general anesthesia and treatment][1] rendered by a dentist [1][for a medical condition covered by the contract][1] regardless of where the [1]dental[1] services are provided.

b. A group or individual health service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual health service corporation contracts in which the health service corporation has reserved the right to change the premium.

[2][6.] 4.[2] a. No individual health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder [1]who is severely disabled or a child age five or under[1] for expenses incurred for [1]: (1)[1] general anesthesia and hospitalization for dental services [1][provided to a covered person who has]; or (2)[1] a medical condition [1][and] covered by the contract which[1] requires hospitalization or general anesthesia for dental services [1][; and general anesthesia and treatment][1] rendered by a dentist [1][for a medical condition covered by the policy][1] regardless of where the [1]dental[1] services are provided.

b. An individual health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all individual health insurance policies in which the insurer has reserved the right to change the premium.

[2][7.] 5.[2] a. No group health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder [1]who is severely disabled or

a child age five or under[1] for expenses incurred for [1]: (1)[1] general anesthesia and hospitalization for dental services [1][provided to a covered person who has]; or (2)[1] a medical condition [1][and] covered by the contract which[1] requires hospitalization or general anesthesia for dental services [1][; and general anesthesia and treatment][1] rendered by a dentist [1][for a medical condition covered by the policy][1] regardless of where the [1]dental[1] services are provided.

b. A group health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group health insurance policies in which the insurer has reserved the right to change the premium.

[2][8. Section 59 of P.L.1991, c.187 (C.26:2J-4.3) is amended to read as follows:

59. a. The coverages for basic health care services offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) shall be limited to the following services:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each enrollee for services provided for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical services for each enrollee for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity services, including delivery and prenatal care;

(4) Out-of-hospital physical examination, including related

【X-rays】 appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For enrollees who are less than two years of age, up to six examinations during the first two years of life; for enrollees who are minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For enrollees who are adults less than 40 years of age, one examination every five years; for enrollees who are 40 or more years of age but less than 60 years of age, one examination every three years; and for enrollees who are 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization may provide alternative coverage for services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be an enrollee under coverage required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(2) A health maintenance organization shall not provide coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) may contain or provide coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity services covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverage of services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health maintenance organization shall file copies of all forms for coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 26 of P.L.1995, c.73 (C.26:2J-44) provided, however, that coverage forms shall be effective only with respect to those coverage form filings which are accompanied by an explanation and identification of the changes being

made on a form prescribed by the commissioner.

These forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health maintenance organization shall file all rates and supplementary rate information and all changes and amendments thereof for the coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The Commissioner of Banking and Insurance shall issue regulations to establish minimum standards for loss ratios under coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

g. Notwithstanding any provision of law to the contrary, a health maintenance organization shall not be required, in regard to coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), to provide mandatory health care benefits or services or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2), including standards for terms and conditions of health care service coverages required to be offered pursuant to this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2) and schedules of benefits for coverage of services provided for in subsection a. of this section.

i. Every health maintenance organization shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) that were sold in the preceding calendar year and the number of enrollees under each type of coverage. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

j. A health maintenance organization which complies with the basic

health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42 U.S.C.s.300e et seq.), shall be deemed in compliance with this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2).
(cf: P.L.1995, c.73, s.27)]2

2[9.] 6.2 a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this amendatory and supplementary act unless the health maintenance organization 1[offers] provides1 health care services to 1[any] an1 enrollee 1[which include] who is severely disabled or a child age five or under for: (1)1 general anesthesia and hospitalization for dental services 1[provided to a covered person who has]; or (2)1 a medical condition 1[and] covered by the enrollee agreement which1 requires hospitalization or general anesthesia for dental services 1[; and general anesthesia and treatment]1 rendered by a 1participating1 dentist 1[for a medical condition covered by the health maintenance organization]1 regardless of where the 1dental1 services are provided.

b. A health maintenance organization may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all contracts for health care services in which the health maintenance organization has reserved the right to change the schedule of charges.

2[10.] 7.2 This act shall take effect 90 days following enactment.

Requires health insurance coverage for certain dental procedures.

ASSEMBLY, No. 1913

STATE OF NEW JERSEY

208th LEGISLATURE

INTRODUCED MARCH 30, 1998

Sponsored by:
Assemblyman JOHN S. WISNIEWSKI
District 19 (Middlesex)
Assemblyman CHRISTOPHER "KIP" BATEMAN
District 16 (Morris and Somerset)

Co-Sponsored by:
Assemblyman Biondi

SYNOPSIS

Requires health insurance coverage for certain dental procedures.

CURRENT VERSION OF TEXT

As introduced.

AN ACT requiring health insurance coverage for certain dental procedures and amending and supplementing various parts of the statutory law.

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

1. (New section) a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder for expenses incurred for general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the contract regardless of where the services are provided.

b. A group or individual hospital service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to read as follows:

53. a. A basic health care contract offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on

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.

the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related [X-rays] appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a medical service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

(2) A medical service corporation shall not sell a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be

payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a medical service corporation shall file copies of all forms of contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 8 of P.L.1995, c.73 (C.17:48A-9.2), provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a medical service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum standards for loss ratios under contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

g. Notwithstanding any provision of law to the contrary, a medical service corporation shall not be required, in regard to contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes

of this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every medical service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1995, c.73, s.10)

3. (New section) a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder for expenses incurred for general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the contract regardless of where the services are provided.

b. A group or individual medical service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

4. Section 55 of P.L.1991, c.187 (C.17:48E-22.2) is amended to read as follows:

55. a. A basic health care contract offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care

and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related [X-rays] appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

(2) A health service corporation shall not sell a contract required to be offered pursuant to section 54 of P.L.1991, c.187

(C.17:48E-22.1) to a group which was covered by health benefits or health insurance any time during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health service corporation shall file copies of all forms of contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to its effective date specifying in what respects the form is not in compliance with the standards set forth in this subsection, any such contract form filed with the commissioner shall be deemed approved as of its effective date, provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum

standards for loss ratios under contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

g. Notwithstanding any provision of law to the contrary, a health service corporation shall not be required, in regard to contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every health service corporation shall report annually on or before March 1 to the Department of <u>Banking and</u> Insurance the number of individual and group contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1991, c.187, s.55)

5. (New section) a. No group or individual health service corporation contract providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder for expenses incurred for general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the contract regardless of where the services are provided.

b. A group or individual health service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual health service corporation contracts in which the health service corporation has

reserved the right to change the premium.

6. (New section) a. No individual health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder for expenses incurred for general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the policy regardless of where the services are provided.

b. An individual health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all individual health insurance policies in which the insurer has reserved the right to change the premium.

7. (New section) a. No group health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder for expenses incurred for general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the policy regardless of where the services are provided.

b. A group health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group health insurance policies in which the insurer has reserved the right to change the premium.

8. Section 59 of P.L.1991, c.187 (C.26:2J-4.3) is amended to read as follows:

59. a. The coverages for basic health care services offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) shall be

limited to the following services:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each enrollee for services provided for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and **[**X-ray**]** appropriate diagnostic imaging and **[**laboratory**]** clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical services for each enrollee for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity services, including delivery and prenatal care;

(4) Out-of-hospital physical examination, including related **[**X-rays**]** appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For enrollees who are less than two years of age, up to six examinations during the first two years of life; for enrollees who are minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For enrollees who are adults less than 40 years of age, one examination every five years; for enrollees who are 40 or more years of age but less than 60 years of age, one examination every three years; and for enrollees who are 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization may provide alternative coverage for services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be an enrollee

under coverage required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(2) A health maintenance organization shall not provide coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) may contain or provide coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity services covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverage of services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health maintenance organization shall file copies of all forms for coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 26 of P.L.1995, c.73 (C.26:2J-44) provided, however, that coverage forms shall be effective only with respect to those coverage form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

These forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health maintenance organization shall file all rates and supplementary rate information and all changes and amendments thereof for the coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The Commissioner of Banking and Insurance shall issue regulations to establish minimum standards for loss ratios under

coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

g. Notwithstanding any provision of law to the contrary, a health maintenance organization shall not be required, in regard to coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), to provide mandatory health care benefits or services or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2), including standards for terms and conditions of health care service coverages required to be offered pursuant to this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2) and schedules of benefits for coverage of services provided for in subsection a. of this section.

i. Every health maintenance organization shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) that were sold in the preceding calendar year and the number of enrollees under each type of coverage. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

j. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42 U.S.C.s.300e et seq.), shall be deemed in compliance with this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(cf: P.L.1995, c.73, s.27)

9. (New section) a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this amendatory and supplementary act unless the health maintenance organization offers health care services to any enrollee which include general anesthesia and hospitalization for dental services provided to a covered person who has a medical condition and requires hospitalization or general anesthesia for dental services; and general anesthesia and treatment rendered by a dentist for a medical condition covered by the health maintenance organization regardless of where the services are provided.

b. A health maintenance organization may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all contracts for health care services in which the health maintenance organization has reserved the right to change the schedule of charges.

10. This act shall take effect 90 days following enactment.

STATEMENT

The bill requires all health insurers and health maintenance organizations to provide benefits to cover anesthesia and hospital charges for dental services provided to any covered person who is a child under age five; is severely disabled; or has a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. However, the bill also allows an insurer or health maintenance organization to require prior authorization of hospitalization for dental services procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1913

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 1, 1998

The Assembly Banking and Insurance Committee reports favorably and with committee amendments, Assembly Bill No. 1903.

This bill, as amended by the committee, requires health insurers and health maintenance organizations to provide coverage for dental services provided to any covered person who is severely disabled or a child age five or under for (1) general anesthesia and hospital charges or (2) a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. The bill also provides that an insurer or health maintenance organization may require prior authorization of hospitalization for dental services procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

SENATE HEALTH COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 1913

with committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 15, 1998

The Senate Health Committee reports favorably and with committee amendments Assembly Bill No. 1913 (1R).

As amended by committee, this bill requires health insurers and health maintenance organizations to provide coverage for dental services provided to any covered person who is severely disabled or a child age five or under for (1) general anesthesia and hospital charges or (2) a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. The bill also provides that an insurer or health maintenance organization may require prior authorization of hospitalization for dental services procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

The committee amended the bill to delete sections 2, 4 and 8 of the bill which amended and updated terminology in the law governing the "bare bones" or basic policies. The basic policies are no longer offered for sale to individuals under the New Jersey Individual Health Coverage Program.

As amended by committee, this bill is identical to Senate Bill No. 1265 SCA, which the committee also reported favorably on this date.

SENATE, No. 1265

STATE OF NEW JERSEY

208th LEGISLATURE

INTRODUCED JUNE 29, 1998

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator JACK SINAGRA
District 18 (Middlesex)

SYNOPSIS

Requires health insurance coverage for certain dental procedures.

CURRENT VERSION OF TEXT

As introduced.

AN ACT requiring health insurance coverage for certain dental procedures and amending and supplementing various parts of the statutory law.

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

1. (New section) a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for : (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual hospital service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to read as follows:

53. a. A basic health care contract offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on

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

the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related [X-rays] appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a medical service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

(2) A medical service corporation shall not sell a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be

payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a medical service corporation shall file copies of all forms of contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 8 of P.L.1995, c.73 (C.17:48A-9.2), provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a medical service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum standards for loss ratios under contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

g. Notwithstanding any provision of law to the contrary, a medical service corporation shall not be required, in regard to contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes

of this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every medical service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1995, c.73, s.10)

3. (New section) a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual medical service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

4. Section 55 of P.L.1991, c.187 (C.17:48E-22.2) is amended to read as follows:

55. a. A basic health care contract offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care

and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and [X-ray] appropriate diagnostic imaging and [laboratory] clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related [X-rays] appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

(2) A health service corporation shall not sell a contract required to be offered pursuant to section 54 of P.L.1991, c.187

(C.17:48E-22.1) to a group which was covered by health benefits or health insurance any time during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health service corporation shall file copies of all forms of contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to its effective date specifying in what respects the form is not in compliance with the standards set forth in this subsection, any such contract form filed with the commissioner shall be deemed approved as of its effective date, provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum

standards for loss ratios under contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

g. Notwithstanding any provision of law to the contrary, a health service corporation shall not be required, in regard to contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every health service corporation shall report annually on or before March 1 to the Department of <u>Banking and</u> Insurance the number of individual and group contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1991, c.187, s.55)

5. (New section) a. No group or individual health service corporation contract providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual health service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual health service

corporation contracts in which the health service corporation has reserved the right to change the premium.

6. (New section) a. No individual health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. An individual health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all individual health insurance policies in which the insurer has reserved the right to change the premium.

7. (New section) a. No group health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group health insurance policies in which the insurer has reserved the right to change the premium.

8. Section 59 of P.L.1991, c.187 (C.26:2J-4.3) is amended to read as follows:

59. a. The coverages for basic health care services offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) shall be limited to the following services:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each enrollee for services provided for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and **[**X-ray**]** appropriate diagnostic imaging and **[**laboratory**]** clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical services for each enrollee for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity services, including delivery and prenatal care;

(4) Out-of-hospital physical examination, including related **[**X-rays**]** appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For enrollees who are less than two years of age, up to six examinations during the first two years of life; for enrollees who are minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For enrollees who are adults less than 40 years of age, one examination every five years; for enrollees who are 40 or more years of age but less than 60 years of age, one examination every three years; and for enrollees who are 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization may provide alternative coverage for services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be an enrollee under coverage required to be offered pursuant to section 58 of

P.L.1991, c.187 (C.26:2J-4.2).

(2) A health maintenance organization shall not provide coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) may contain or provide coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity services covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverage of services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health maintenance organization shall file copies of all forms for coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 26 of P.L.1995, c.73 (C.26:2J-44) provided, however, that coverage forms shall be effective only with respect to those coverage form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

These forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health maintenance organization shall file all rates and supplementary rate information and all changes and amendments thereof for the coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The Commissioner of Banking and Insurance shall issue regulations to establish minimum standards for loss ratios under coverages required to be offered pursuant to section 58 of P.L.1991,

c.187 (C.26:2J-4.2).

g. Notwithstanding any provision of law to the contrary, a health maintenance organization shall not be required, in regard to coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), to provide mandatory health care benefits or services or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2), including standards for terms and conditions of health care service coverages required to be offered pursuant to this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2) and schedules of benefits for coverage of services provided for in subsection a. of this section.

i. Every health maintenance organization shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) that were sold in the preceding calendar year and the number of enrollees under each type of coverage. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

j. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42 U.S.C.s.300e et seq.), shall be deemed in compliance with this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(cf: P.L.1995, c.73, s.27)

9. (New section) a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this amendatory and supplementary act unless the health maintenance organization provides health care services to an enrollee who is severely disabled or a child age five or under for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the enrollee agreement which requires hospitalization or general anesthesia for dental services rendered by a participating dentist regardless of where the dental services are provided.

b. A health maintenance organization may require prior

authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all contracts for health care services in which the health maintenance organization has reserved the right to change the schedule of charges.

10. This act shall take effect 90 days following enactment.

STATEMENT

This bill, requires health insurers and health maintenance organizations to provide coverage for dental services provided to any covered person who is severely disabled or a child age five or under for (1) general anesthesia and hospital charges or (2) a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. The bill also provides that a health insurer or health maintenance organization may require prior authorization of hospitalization for dental services procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 1265

with committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 15, 1998

The Senate Health Committee reports favorably and with committee amendments Senate Bill No. 1265.

As amended by committee, this bill requires health insurers and health maintenance organizations to provide coverage for dental services provided to any covered person who is severely disabled or a child age five or under for (1) general anesthesia and hospital charges or (2) a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. The bill also provides that an insurer or health maintenance organization may require prior authorization of hospitalization for dental services procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

The committee amended the bill to delete sections 2, 4 and 8 of the bill which amended and updated terminology in the law governing the "bare bones" or basic policies. The basic policies are no longer offered for sale to individuals under the New Jersey Individual Health Coverage Program.

As amended by committee, this bill is identical to Assembly Bill No. 1913(1R) SCA, which the committee also reported favorably on this date.

[First Reprint]

SENATE, No. 1265

STATE OF NEW JERSEY

208th LEGISLATURE

INTRODUCED JUNE 29, 1998

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator JACK SINAGRA
District 18 (Middlesex)

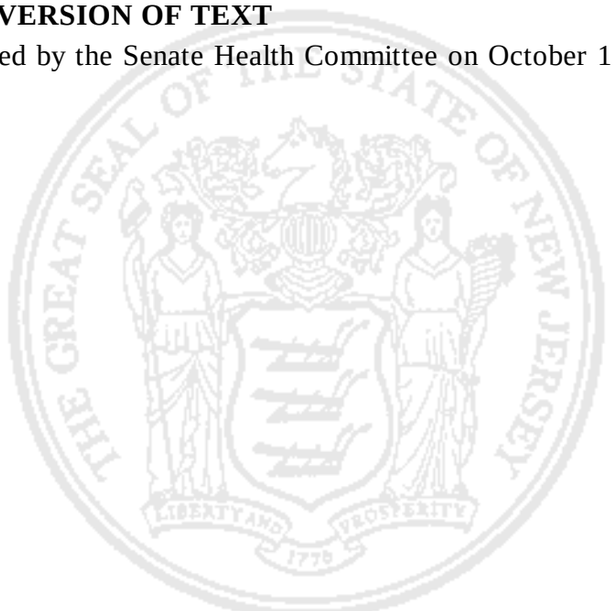
Co-Sponsored by:
Senator Rice

SYNOPSIS

Requires health insurance coverage for certain dental procedures.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee on October 15, 1998, with amendments.



(Sponsorship Updated As Of: 12/18/1998)

AN ACT requiring health insurance coverage for certain dental procedures [1]**[**and amending**]**[1] and supplementing various parts of the statutory law.

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

1. a. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for : (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual hospital service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

[1]**[**2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to read as follows:

53. a. A basic health care contract offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

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 SHH committee amendments adopted October 15, 1998.

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and ⟦X-ray⟧ appropriate diagnostic imaging and ⟦laboratory⟧ clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related ⟦X-rays⟧ appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a medical service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

(2) A medical service corporation shall not sell a contract required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) may contain or provide for

coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a medical service corporation shall file copies of all forms of contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 8 of P.L.1995, c.73 (C.17:48A-9.2), provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a medical service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum standards for loss ratios under contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8).

g. Notwithstanding any provision of law to the contrary, a medical service corporation shall not be required, in regard to contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 52 of P.L.1991, c.187 (C.17:48A-6.8) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every medical service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1995, c.73, s.10)**]**[1]

[1]**[**3.**]** 2.[1] a. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual medical service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

[1]**[**4. Section 55 of P.L.1991, c.187 (C.17:48E-22.2) is amended to read as follows:

55. a. A basic health care contract offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) shall provide:

(1) Basic hospital expense coverage for a period of 21 days in a benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and **[**X-ray**]** appropriate diagnostic imaging and **[**laboratory**]** clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity benefits, including cost of delivery and prenatal care;

(4) Out-of-hospital physical examination, including related **[**X-rays**]** appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For covered minors of less than two years of age, up to six examinations during the first two years of life; for covered minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For covered adults of less than 40 years of age, one examination every five years; for covered adults 40 or more years of age but less than 60 years of age, one examination every three years; and for covered adults 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health service corporation may provide alternative benefits or services from those required by this subsection if they are approved by the Commissioner of Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered person under a contract required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

(2) A health service corporation shall not sell a contract required

to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) to a group which was covered by health benefits or health insurance any time during the 12-month period immediately preceding the effective date of coverage.

c. (1) Contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) may contain or provide for coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity benefits covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverages required to be offered pursuant to this section, subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health service corporation shall file copies of all forms of contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to its effective date specifying in what respects the form is not in compliance with the standards set forth in this subsection, any such contract form filed with the commissioner shall be deemed approved as of its effective date, provided, however, that contract forms shall be effective only with respect to those contract form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Contract forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health service corporation shall file all rates and supplementary rate information and all changes and amendments thereof for the contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for approval with the commissioner at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date. In his discretion, the commissioner may waive the 60-day waiting period or any portion thereof.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The commissioner shall issue regulations to establish minimum standards for loss ratios under contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1).

g. Notwithstanding any provision of law to the contrary, a health service corporation shall not be required, in regard to contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1), to provide mandatory health care benefits or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The commissioner shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1), including standards for terms and conditions of contracts required to be offered pursuant to this section and section 54 of P.L.1991, c.187 (C.17:48E-22.1) and schedules of benefits for coverages provided for in subsection a. of this section.

i. Every health service corporation shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group contracts required to be offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) that were sold in the preceding calendar year and the number of persons covered under each type of contract. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

(cf: P.L.1991, c.187, s.55)**]**[1]

[1]**[**5.**]** 3.[1] a. No group or individual health service corporation contract providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the contract provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group or individual health service corporation contract may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group or individual health service corporation contracts in which the health service corporation has

reserved the right to change the premium.

[1][6.]4.[1] a. No individual health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. An individual health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all individual health insurance policies in which the insurer has reserved the right to change the premium.

[1][7.] 5.[1] a. No group health insurance policy providing hospital or medical benefits shall be delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act, unless the policy provides benefits to any person covered thereunder who is severely disabled or a child age five or under for expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the contract which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

b. A group health insurance policy may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all group health insurance policies in which the insurer has reserved the right to change the premium.

[1][8. Section 59 of P.L.1991, c.187 (C.26:2J-4.3) is amended to read as follows:

59. a. The coverages for basic health care services offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) shall be limited to the following services:

(1) Basic hospital expense coverage for a period of 21 days in a

benefit year for each enrollee for services provided for medically necessary treatment and services rendered as a result of injury or sickness, including:

(a) Daily hospital room and board, including general nursing care and special diets;

(b) Miscellaneous hospital services, including services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(c) Hospital outpatient services consisting of hospital services on the day surgery is performed; hospital services rendered within 72 hours after accidental injury; and **[**X-ray**]** appropriate diagnostic imaging and **[**laboratory**]** clinical tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

(2) Basic medical-surgical services for each enrollee for medically necessary services for treatment of injury or sickness for the following:

(a) Surgical services;

(b) Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical or dental services rendered by a physician other than the physician or dentist performing the surgical services;

(c) In-hospital services rendered to a person who is confined to a hospital for treatment of injury or sickness other than that for which surgical care is required;

(3) Maternity services, including delivery and prenatal care;

(4) Out-of-hospital physical examination, including related **[**X-rays**]** appropriate diagnostic imaging and other diagnostic tests, on the following basis:

(a) For enrollees who are less than two years of age, up to six examinations during the first two years of life; for enrollees who are minors of two years of age or older, one examination at age 3, 6, 9, 12, 15 and 18 years;

(b) For enrollees who are adults less than 40 years of age, one examination every five years; for enrollees who are 40 or more years of age but less than 60 years of age, one examination every three years; and for enrollees who are 60 years of age or older, one examination every two years.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization may provide alternative coverage for services from those required by this subsection if they are approved by the Commissioner of Banking and Insurance and are within the intent of this amendatory and supplementary act.

b. (1) No person who is eligible for coverage under Medicare pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be an enrollee under coverage required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(2) A health maintenance organization shall not provide coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) to a group which was covered by health benefits or health insurance anytime during the 12-month period immediately preceding the effective date of coverage.

c. (1) Coverage for services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) may contain or provide coinsurance or deductibles, or both; except that no deductible shall be payable in excess of a total of $250 by an individual or family unit during any benefit year, no coinsurance shall be payable in excess of a total of $500 by an individual or family unit during any benefit year, and neither coinsurance nor deductibles shall apply to physical examinations or maternity services covered pursuant to paragraphs (3) or (4) of subsection a. of this section.

(2) Managed care systems may be utilized for coverage of services required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), subject to the review and approval of the Commissioner of Banking and Insurance.

d. Notwithstanding any other law to the contrary, a health maintenance organization shall file copies of all forms for coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance in accordance with the provisions of section 26 of P.L.1995, c.73 (C.26:2J-44) provided, however, that coverage forms shall be effective only with respect to those coverage form filings which are accompanied by an explanation and identification of the changes being made on a form prescribed by the commissioner.

These forms shall not be unfair, inequitable, misleading or contrary to law, nor shall they produce rates that are excessive, inadequate or unfairly discriminatory.

e. Notwithstanding any other law to the contrary, a health maintenance organization shall file all rates and supplementary rate information and all changes and amendments thereof for the coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) for approval with the Commissioner of Banking and Insurance at least 60 days prior to becoming effective. Unless disapproved by the commissioner prior to their effective date specifying in what respects the filing is not in compliance with the standards set forth in this subsection, any such rates, supplementary rate information, changes or amendments filed with the commissioner shall be deemed approved as of their effective date.

Rates shall not be excessive, inadequate or unfairly discriminatory.

f. The Commissioner of Banking and Insurance shall issue regulations to establish minimum standards for loss ratios under coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2).

g. Notwithstanding any provision of law to the contrary, a health maintenance organization shall not be required, in regard to coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2), to provide mandatory health care benefits or services or provide benefits for services rendered by providers of health care services as otherwise required by law.

h. The Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services shall, pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations necessary to effectuate the purposes of this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2), including standards for terms and conditions of health care service coverages required to be offered pursuant to this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2) and schedules of benefits for coverage of services provided for in subsection a. of this section.

i. Every health maintenance organization shall report annually on or before March 1 to the Department of Banking and Insurance the number of individual and group coverages required to be offered pursuant to section 58 of P.L.1991, c.187 (C.26:2J-4.2) that were sold in the preceding calendar year and the number of enrollees under each type of coverage. The department shall compile and analyze this information and shall report annually on or before July 1 its findings and any recommendations it may have to the Governor and the Legislature.

j. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42 U.S.C.s.300e et seq.), shall be deemed in compliance with this section and section 58 of P.L.1991, c.187 (C.26:2J-4.2).

(cf: P.L.1995, c.73, s.27)**]**[1]

[1]**[**9.**]** 6.[1] a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this amendatory and supplementary act unless the health maintenance organization provides health care services to an enrollee who is severely disabled or a child age five or under for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the enrollee agreement which requires hospitalization or general anesthesia for dental services rendered by a participating dentist regardless of where the dental services are provided.

b. A health maintenance organization may require prior authorization of hospitalization for dental services in the same manner

that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all contracts for health care services in which the health maintenance organization has reserved the right to change the schedule of charges.

[1]**[**10.**]** 7.[1] This act shall take effect 90 days following enactment.

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Office of the Governor
NEWS RELEASE

RELEASE: March 15, 1999

Gov. Christie Whitman today signed the following pieces of legislation:

A-2246, sponsored by Assembly Members Joseph Azzolina (R-Middlesex/Monmouth) and Samuel D. Thompson (R-Middlesex/Monmouth) and Senators James S. Cafiero (R-Cape May/Atlantic/ Cumberland) and Diane B. Allen (R-Burlington/Camden), amends the current stalking law and provides for temporary restraining orders to protect children and certain adults who are victims of stalking. The legislation amends the stalking statute to provide that a person is guilty of stalking when he or she purposely or knowingly engages in a course of conduct that would cause reasonable persons to fear bodily injury to themselves or family members. By removing the "subjective fear" requirement from the state statute, which required the victim to actually be put in fear, the statute now reaches circumstances where the victim, perhaps due to age or disability, is unable to perceive or understand the threat posed by the stalker. In addition, the bill expands the statute to reach circumstances where the stalker's intent may not have been to cause fear, but where the stalker knew that his or her conduct would cause a reasonable person to fear bodily injury or death. The bill also allows the parent or guardian of a minor or mentally-disabled stalking victim to apply for a temporary restraining order to prevent the stalker from having contact with the victim. The temporary restraining order may remain in place until a conviction is secured or the parent or guardian requests that it be lifted and the court finds just cause to do so.

S-1093, sponsored by Senators Gerald Cardinale (R-Bergen) and Raymond J. Lesniak (D-Union), amends the "Franchise Practices Act" in regard to motor vehicle franchises. The bill clarifies and reinforces existing law so that motor vehicle dealers will not be drawn into costly litigation in order to protect their rights and the consumer interest in the franchise system. The bill clarifies current aspects of the law that prohibit motor vehicle manufacturers from refusing a dealer the opportunity to sell all models manufactured for that line-make. In addition, the legislation prohibits a manufacturer from opening separate service centers, except in cooperation with an existing motor vehicle franchise. The legislation provides a number of protections for motor vehicle dealers, many involving warranty issues. Currently, the "Franchise Practices Act" requires motor vehicle manufacturers to reimburse their dealers for the warranty repairs made by the dealer. Dealers are reimbursed at the rate at which they charge their customers for similar work. However, dealers have been subjected to costly litigation when manufacturers challenged the method used to calculate the retail price. The bill clarifies this along with other warranty issues by (1) defining how a dealer's rate for parts reimbursement is to be calculated; (2) extending the retail reimbursement requirement to services and repair plans administered by manufacturers; (3) requiring the manufacturer to make payment equivalent to the dealer's average percentage markup when a warranty part is delivered in bulk (engine and transmission assemblies are the exception and the markup is specified at 30 % due to high cost); and (4) placing limits on the time within which the manufacturer must pay a dealer for an audit for warranty reimbursement claims.

A-2839, sponsored by Assembly Members Joseph V. Doria, Jr. (D- Hudson) and Paul DiGaetano (R-Bergen/Essex/Passaic) and Senator Edward T. O'Connor, Jr. (D-Hudson), allows local governments to participate in the State Health Benefits Program (SHBP) in a manner that is competitive with private insurers. Local governments will be allowed to participate in the SHBP in a competitive manner by negotiating health benefits for retirees. Currently, local governments are only allowed to negotiate health benefits for retirees with private insurers. Allowing the SHBP to be part of the competitive process will allow interested local governments to receive the benefits of the state's lower administrative costs.

A-1913, sponsored by Assembly Members John S. Wisniewski (D- Middlesex) and Christopher "Kip" Bateman (R-Morris/Somerset) and Senators Joseph F. Vitale (D-Middlesex) and Jack Sinagra (R-Middlesex), requires health insurers to cover anesthetic procedures associated with dental surgery and other procedures. The bill requires health insurers and health maintenance organizations to provide coverage for dental services provided to any covered person who is severely disabled or who is a child, age five or under, for (1) general anesthesia and hospital charges or (2) a medical condition requiring hospitalization or general anesthesia for dental services, regardless of where treatment is provided. The anesthetic procedures that would be covered by this bill are procedures that would not be required on a typical, healthy, adult, but, instead, would be necessary on a person with severe disabilities or on a young child that could not otherwise sit still for the dental procedure. The bill also provides that an insurer or health maintenance organization may require prior authorization of hospitalization for dental procedures in the same manner that prior authorization is required for other covered diseases or conditions.