

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*

§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*)

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

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

7
8 1. a. No group or individual hospital service corporation contract
9 providing hospital or medical expense benefits shall be delivered,
10 issued, executed or renewed in this State pursuant to P.L.1938, c.366
11 (C.17:48-1 et seq.), or approved for issuance or renewal in this State
12 by the Commissioner of Banking and Insurance on or after the
13 effective date of this amendatory and supplementary act, unless the
14 contract provides benefits to any person covered thereunder ¹ who is
15 severely disabled or a child age five or under ¹ for expenses incurred
16 for ¹: (1) ¹ general anesthesia and hospitalization for dental services
17 ¹ [provided to a covered person who has] ; or (2) ¹ a medical condition
18 ¹ [and] covered by the contract which ¹ requires hospitalization or
19 general anesthesia for dental services ¹ [; and general anesthesia and
20 treatment] ¹ rendered by a dentist ¹ [for a medical condition covered
21 by the contract] ¹ regardless of where the ¹ dental ¹ services are
22 provided.

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

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

30
31 ² [2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to
32 read as follows:

33 53. a. A basic health care contract offered pursuant to section 52
34 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 (1) Basic hospital expense coverage for a period of 21 days in a
2 benefit year for each covered person for expenses incurred for
3 medically necessary treatment and services rendered as a result of
4 injury or sickness, including:

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

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

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

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

20 (a) Surgical services;

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

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

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

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

32 (a) For covered minors of less than two years of age, up to six
33 examinations during the first two years of life; for covered minors of
34 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
35 18 years;

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

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

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

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

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

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

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

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

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

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

45 Rates shall not be excessive, inadequate or unfairly discriminatory.

46 f. The commissioner shall issue regulations to establish minimum

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

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

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

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

26 (cf: P.L.1995, c.73, s.10)]²

27

28 ²[3.] 2.² a. No group or individual medical service corporation
29 contract providing hospital or medical expense benefits shall be
30 delivered, issued, executed or renewed in this State pursuant to
31 P.L.1940, c.74 ¹[(C.17:48-1 et seq.)] (C.17:48A-1 et seq.)¹, or
32 approved for issuance or renewal in this State by the Commissioner of
33 Banking and Insurance on or after the effective date of this
34 amendatory and supplementary act, unless the contract provides
35 benefits to any person covered thereunder ¹who is severely disabled or
36 a child age five or under¹ for expenses incurred for ¹: (1)¹ general
37 anesthesia and hospitalization for dental services ¹[provided to a
38 covered person who has] ; or (2)¹ a medical condition ¹[and] covered
39 by the contract which¹ requires hospitalization or general anesthesia
40 for dental services ¹[; and general anesthesia and treatment]¹ rendered
41 by a dentist ¹[for a medical condition covered by the contract]¹
42 regardless of where the ¹dental¹ services are provided.

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

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

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

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

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

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

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

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

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

28 (a) Surgical services;

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

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

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

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

40 (a) For covered minors of less than two years of age, up to six
41 examinations during the first two years of life; for covered minors of
42 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
43 18 years;

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

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

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

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

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

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

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

29 d. Notwithstanding any other law to the contrary, a health service
30 corporation shall file copies of all forms of contracts required to be
31 offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for
32 approval with the Commissioner of Banking and Insurance at least 60
33 days prior to becoming effective. Unless disapproved by the
34 commissioner prior to its effective date specifying in what respects the
35 form is not in compliance with the standards set forth in this
36 subsection, any such contract form filed with the commissioner shall
37 be deemed approved as of its effective date, provided, however, that
38 contract forms shall be effective only with respect to those contract
39 form filings which are accompanied by an explanation and
40 identification of the changes being made on a form prescribed by the
41 commissioner. In his discretion, the commissioner may waive the
42 60-day waiting period or any portion thereof.

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

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

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

12 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

39 (cf: P.L.1991, c.187, s.55)]²

40

41 ²[5.] 3.² a. No group or individual health service corporation
42 contract providing hospital or medical benefits shall be delivered,
43 issued, executed or renewed in this State pursuant to P.L.1985, c.236
44 ¹[(C.17:48-1 et seq.)] (C.17:48E-1 et seq.)¹, or approved for issuance
45 or renewal in this State by the Commissioner of Banking and Insurance
46 on or after the effective date of this amendatory and supplementary

1 act, unless the contract provides benefits to any person covered
2 thereunder ¹who is severely disabled or a child age five or under¹ for
3 expenses incurred for ¹: (1)¹ general anesthesia and hospitalization for
4 dental services ¹provided to a covered person who has; or (2)¹ a
5 medical condition ¹and covered by the contract which¹ requires
6 hospitalization or general anesthesia for dental services ¹; and general
7 anesthesia and treatment¹ rendered by a dentist ¹for a medical
8 condition covered by the contract¹ regardless of where the
9 ¹dental¹ services are provided.

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

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

17

18 ²[6.] 4.² a. No individual health insurance policy providing
19 hospital or medical benefits shall be delivered, issued, executed or
20 renewed in this State pursuant to chapter 26 of Title 17B of the New
21 Jersey Statutes, or approved for issuance or renewal in this State by
22 the Commissioner of Banking and Insurance on or after the effective
23 date of this amendatory and supplementary act, unless the policy
24 provides benefits to any person covered thereunder ¹who is severely
25 disabled or a child age five or under¹ for expenses incurred for ¹: (1)¹
26 general anesthesia and hospitalization for dental services ¹provided
27 to a covered person who has; or (2)¹ a medical condition ¹and
28 covered by the contract which¹ requires hospitalization or general
29 anesthesia for dental services ¹; and general anesthesia and
30 treatment¹ rendered by a dentist ¹for a medical condition covered
31 by the policy¹ regardless of where the ¹dental¹ services are provided.

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

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

38

39 ²[7.] 5.² a. No group health insurance policy providing hospital
40 or medical benefits shall be delivered, issued, executed or renewed in
41 this State pursuant to chapter 27 of Title 17B of the New Jersey
42 Statutes, or approved for issuance or renewal in this State by the
43 Commissioner of Banking and Insurance on or after the effective date
44 of this amendatory and supplementary act, unless the policy provides
45 benefits to any person covered thereunder ¹who is severely disabled or

1 a child age five or under¹ for expenses incurred for ¹: (1)¹ general
2 anesthesia and hospitalization for dental services ¹【provided to a
3 covered person who has】; or (2)¹ a medical condition ¹【and】 covered
4 by the contract which¹ requires hospitalization or general anesthesia
5 for dental services ¹【; and general anesthesia and treatment】¹ rendered
6 by a dentist ¹【for a medical condition covered by the policy】¹
7 regardless of where the ¹dental¹ services are provided.

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

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

14

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

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

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

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

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

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

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

37 (a) Surgical services;

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

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

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

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

1 **[X-rays]** appropriate diagnostic imaging and other diagnostic tests, on
2 the following basis:

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

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

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

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

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

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

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

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

1 made on a form prescribed by the commissioner.

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

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

16 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

46 j. A health maintenance organization which complies with the basic

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

6
 7 ²[9.] 6.² a. A certificate of authority to establish and operate a
 8 health maintenance organization in this State pursuant to P.L.1973,
 9 c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the
 10 Commissioner of Health and Senior Services on or after the effective
 11 date of this amendatory and supplementary act unless the health
 12 maintenance organization ¹[offers] provides¹ health care services to
 13 ¹[any] an¹ enrollee ¹[which include] who is severely disabled or a
 14 child age five or under for: (1)¹ general anesthesia and hospitalization
 15 for dental services ¹[provided to a covered person who has]; or (2)¹
 16 a medical condition ¹[and] covered by the enrollee agreement which¹
 17 requires hospitalization or general anesthesia for dental services ¹[;
 18 and general anesthesia and treatment]¹ rendered by a ¹participating¹
 19 dentist ¹[for a medical condition covered by the health maintenance
 20 organization]¹ regardless of where the ¹dental¹ services are provided.
 21 b. A health maintenance organization may require prior
 22 authorization of hospitalization for dental services in the same manner
 23 that prior authorization is required for hospitalization for other
 24 covered diseases or conditions.
 25 c. This section shall apply to all contracts for health care services
 26 in which the health maintenance organization has reserved the right to
 27 change the schedule of charges.

28
 29 ²[10.] 7.² This act shall take effect 90 days following enactment.

30
 31
 32
 33
 34 _____
 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.



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

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

7
8 1. (New section) a. No group or individual hospital service
9 corporation contract providing hospital or medical expense benefits
10 shall be delivered, issued, executed or renewed in this State pursuant
11 to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or
12 renewal in this State by the Commissioner of Banking and Insurance
13 on or after the effective date of this amendatory and supplementary
14 act, unless the contract provides benefits to any person covered
15 thereunder for expenses incurred for general anesthesia and
16 hospitalization for dental services provided to a covered person who
17 has a medical condition and requires hospitalization or general
18 anesthesia for dental services; and general anesthesia and treatment
19 rendered by a dentist for a medical condition covered by the contract
20 regardless of where the services are provided.

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

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

28
29 2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to
30 read as follows:

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

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

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

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

43 (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 thus is new matter.

1 the day surgery is performed; hospital services rendered within 72
2 hours after accidental injury; and **【X-ray】** appropriate diagnostic
3 imaging and **【laboratory】** clinical tests to the extent that benefits for
4 such services would have been provided if rendered to an inpatient of
5 the hospital;

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

9 (a) Surgical services;

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

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

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

18 (4) Out-of-hospital physical examination, including related
19 **【X-rays】** appropriate diagnostic imaging and other diagnostic tests, on
20 the following basis:

21 (a) For covered minors of less than two years of age, up to six
22 examinations during the first two years of life; for covered minors of
23 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
24 18 years;

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

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

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

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

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

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

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

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

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

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

34 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

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

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

16

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

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

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

37

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

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

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

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

1 and special diets;

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

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

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

15 (a) Surgical services;

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

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

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

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

27 (a) For covered minors of less than two years of age, up to six
28 examinations during the first two years of life; for covered minors of
29 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
30 18 years;

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

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

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

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

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

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

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

16 d. Notwithstanding any other law to the contrary, a health service
17 corporation shall file copies of all forms of contracts required to be
18 offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for
19 approval with the Commissioner of Banking and Insurance at least 60
20 days prior to becoming effective. Unless disapproved by the
21 commissioner prior to its effective date specifying in what respects the
22 form is not in compliance with the standards set forth in this
23 subsection, any such contract form filed with the commissioner shall
24 be deemed approved as of its effective date, provided, however, that
25 contract forms shall be effective only with respect to those contract
26 form filings which are accompanied by an explanation and
27 identification of the changes being made on a form prescribed by the
28 commissioner. In his discretion, the commissioner may waive the
29 60-day waiting period or any portion thereof.

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

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

45 Rates shall not be excessive, inadequate or unfairly discriminatory.

46 f. The commissioner shall issue regulations to establish minimum

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

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

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

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

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

27

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

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

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

1 reserved the right to change the premium.

2

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

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

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

22

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

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

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

42

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

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

1 limited to the following services:

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

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

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

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

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

19 (a) Surgical services;

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

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

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

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

31 (a) For enrollees who are less than two years of age, up to six
32 examinations during the first two years of life; for enrollees who are
33 minors of two years of age or older, one examination at age 3, 6, 9,
34 12, 15 and 18 years;

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

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

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

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

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

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

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

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

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

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

44 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

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

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

34
35 9. (New section) a. A certificate of authority to establish and
36 operate a health maintenance organization in this State pursuant to
37 P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued
38 by the Commissioner of Health and Senior Services on or after the
39 effective date of this amendatory and supplementary act unless the
40 health maintenance organization offers health care services to any
41 enrollee which include general anesthesia and hospitalization for dental
42 services provided to a covered person who has a medical condition
43 and requires hospitalization or general anesthesia for dental services;
44 and general anesthesia and treatment rendered by a dentist for a
45 medical condition covered by the health maintenance organization
46 regardless of where the services are provided.

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

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

8

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

10

11

12

STATEMENT

13

14 The bill requires all health insurers and health maintenance
15 organizations to provide benefits to cover anesthesia and hospital
16 charges for dental services provided to any covered person who is a
17 child under age five; is severely disabled; or has a medical condition
18 requiring hospitalization or general anesthesia for dental services,
19 regardless of where treatment is provided. However, the bill also
20 allows an insurer or health maintenance organization to require prior
21 authorization of hospitalization for dental services procedures in the
22 same manner that prior authorization is required for hospitalization for
23 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.



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

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

7
8 1. (New section) a. No group or individual hospital service
9 corporation contract providing hospital or medical expense benefits
10 shall be delivered, issued, executed or renewed in this State pursuant
11 to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or
12 renewal in this State by the Commissioner of Banking and Insurance
13 on or after the effective date of this amendatory and supplementary
14 act, unless the contract provides benefits to any person covered
15 thereunder who is severely disabled or a child age five or under for
16 expenses incurred for : (1) general anesthesia and hospitalization for
17 dental services; or (2) a medical condition covered by the contract
18 which requires hospitalization or general anesthesia for dental services
19 rendered by a dentist regardless of where the dental services are
20 provided.

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

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

28
29 2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to
30 read as follows:

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

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

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

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

43 (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 thus is new matter.

1 the day surgery is performed; hospital services rendered within 72
2 hours after accidental injury; and **【X-ray】** appropriate diagnostic
3 imaging and **【laboratory】** clinical tests to the extent that benefits for
4 such services would have been provided if rendered to an inpatient of
5 the hospital;

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

9 (a) Surgical services;

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

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

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

18 (4) Out-of-hospital physical examination, including related
19 **【X-rays】** appropriate diagnostic imaging and other diagnostic tests, on
20 the following basis:

21 (a) For covered minors of less than two years of age, up to six
22 examinations during the first two years of life; for covered minors of
23 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
24 18 years;

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

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

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

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

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

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

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

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

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

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

34 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

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

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

16

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

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

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

37

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

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

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

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

1 and special diets;

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

6 (c) Hospital outpatient services consisting of hospital services on
7 the day surgery is performed; hospital services rendered within
8 72 hours after accidental injury; and **[X-ray]** appropriate diagnostic
9 imaging and **[laboratory]** clinical tests to the extent that benefits for
10 such services would have been provided if rendered to an inpatient of
11 the hospital;

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

15 (a) Surgical services;

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

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

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

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

27 (a) For covered minors of less than two years of age, up to six
28 examinations during the first two years of life; for covered minors of
29 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
30 18 years;

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

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

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

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

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

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

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

16 d. Notwithstanding any other law to the contrary, a health service
17 corporation shall file copies of all forms of contracts required to be
18 offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for
19 approval with the Commissioner of Banking and Insurance at least 60
20 days prior to becoming effective. Unless disapproved by the
21 commissioner prior to its effective date specifying in what respects the
22 form is not in compliance with the standards set forth in this
23 subsection, any such contract form filed with the commissioner shall
24 be deemed approved as of its effective date, provided, however, that
25 contract forms shall be effective only with respect to those contract
26 form filings which are accompanied by an explanation and
27 identification of the changes being made on a form prescribed by the
28 commissioner. In his discretion, the commissioner may waive the
29 60-day waiting period or any portion thereof.

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

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

45 Rates shall not be excessive, inadequate or unfairly discriminatory.

46 f. The commissioner shall issue regulations to establish minimum

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

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

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

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

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

27

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

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

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

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

3

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

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

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

22

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

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

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

41

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

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

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

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

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

10 (c) Hospital outpatient services consisting of hospital services on
11 the day surgery is performed; hospital services rendered within
12 72 hours after accidental injury; and **[X-ray]** appropriate diagnostic
13 imaging and **[laboratory]** clinical tests to the extent that benefits for
14 such services would have been provided if rendered to an inpatient of
15 the hospital;

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

18 (a) Surgical services;

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

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

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

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

30 (a) For enrollees who are less than two years of age, up to six
31 examinations during the first two years of life; for enrollees who are
32 minors of two years of age or older, one examination at age 3, 6, 9,
33 12, 15 and 18 years;

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

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

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

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

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

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

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

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

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

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

43 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

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

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

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

33

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

46 b. A health maintenance organization may require prior

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

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

7

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

9

10

11

STATEMENT

12

13 This bill, requires health insurers and health maintenance
14 organizations to provide coverage for dental services provided to any
15 covered person who is severely disabled or a child age five or under
16 for (1) general anesthesia and hospital charges or (2) a medical
17 condition requiring hospitalization or general anesthesia for dental
18 services, regardless of where treatment is provided. The bill also
19 provides that a health insurer or health maintenance organization may
20 require prior authorization of hospitalization for dental services
21 procedures in the same manner that prior authorization is required for
22 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:

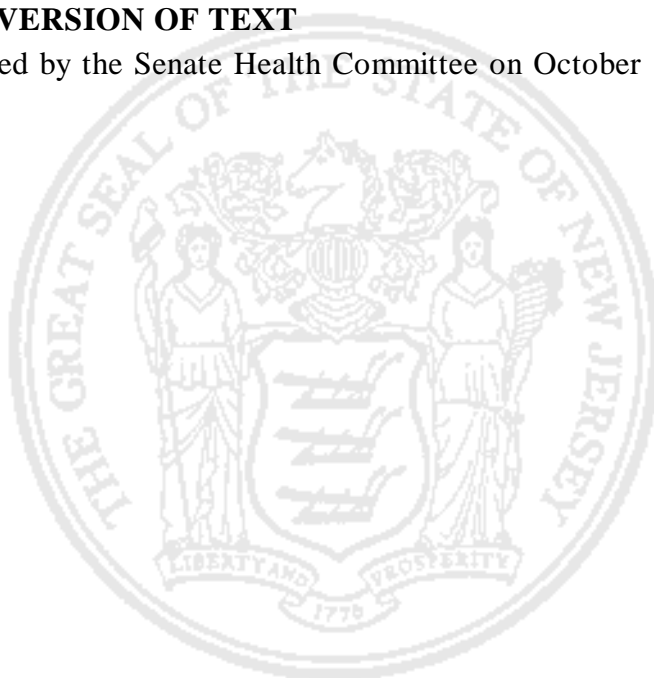
Senator Rice

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)

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

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

7
8 1. a. No group or individual hospital service corporation contract
9 providing hospital or medical expense benefits shall be delivered,
10 issued, executed or renewed in this State pursuant to P.L.1938, c.366
11 (C.17:48-1 et seq.), or approved for issuance or renewal in this State
12 by the Commissioner of Banking and Insurance on or after the
13 effective date of this amendatory and supplementary act, unless the
14 contract provides benefits to any person covered thereunder who is
15 severely disabled or a child age five or under for expenses incurred
16 for : (1) general anesthesia and hospitalization for dental services; or
17 (2) a medical condition covered by the contract which requires
18 hospitalization or general anesthesia for dental services rendered by a
19 dentist regardless of where the dental services are provided.

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

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

27
28 ¹**[2. Section 53 of P.L.1991, c.187 (C.17:48A-6.9) is amended to**
29 read as follows:

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

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

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

38 (b) Miscellaneous hospital services, including expenses incurred for
39 charges made by the hospital for services and supplies which are
40 customarily rendered by the hospital and provided for use only during
41 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 thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted October 15, 1998.

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

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

10 (a) Surgical services;

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

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

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

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

22 (a) For covered minors of less than two years of age, up to six
23 examinations during the first two years of life; for covered minors of
24 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
25 18 years;

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

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

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

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

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

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

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

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

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

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

35 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

7 i. Every medical service corporation shall report annually on or
8 before March 1 to the Department of Banking and Insurance the
9 number of individual and group contracts required to be offered
10 pursuant to section 52 of P.L.1991, c.187 (C.17:48A-6.8) that were
11 sold in the preceding calendar year and the number of persons covered
12 under each type of contract. The department shall compile and
13 analyze this information and shall report annually on or before July 1
14 its findings and any recommendations it may have to the Governor and
15 the Legislature.
16 (cf: P.L.1995, c.73, s.10)]¹

17
18 ¹[3.] 2.¹ a. No group or individual medical service corporation
19 contract providing hospital or medical expense benefits shall be
20 delivered, issued, executed or renewed in this State pursuant to
21 P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
22 renewal in this State by the Commissioner of Banking and Insurance
23 on or after the effective date of this amendatory and supplementary
24 act, unless the contract provides benefits to any person covered
25 thereunder who is severely disabled or a child age five or under for
26 expenses incurred for: (1) general anesthesia and hospitalization for
27 dental services; or (2) a medical condition covered by the contract
28 which requires hospitalization or general anesthesia for dental services
29 rendered by a dentist regardless of where the dental services are
30 provided.

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

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

38

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

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

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

- 1 (a) Daily hospital room and board, including general nursing care
2 and special diets;
- 3 (b) Miscellaneous hospital services, including expenses incurred for
4 charges made by the hospital for services and supplies which are
5 customarily rendered by the hospital and provided for use only during
6 any period of confinement;
- 7 (c) Hospital outpatient services consisting of hospital services on
8 the day surgery is performed; hospital services rendered within
9 72 hours after accidental injury; and **[X-ray]** appropriate diagnostic
10 imaging and **[laboratory]** clinical tests to the extent that benefits for
11 such services would have been provided if rendered to an inpatient of
12 the hospital;
- 13 (2) Basic medical-surgical expense coverage for each covered
14 person for expenses incurred for medically necessary services for
15 treatment of injury or sickness for the following:
- 16 (a) Surgical services;
- 17 (b) Anesthesia services consisting of administration of necessary
18 general anesthesia and related procedures in connection with covered
19 surgical or dental services rendered by a physician other than the
20 physician or dentist performing the surgical services;
- 21 (c) In-hospital services rendered to a person who is confined to a
22 hospital for treatment of injury or sickness other than that for which
23 surgical care is required;
- 24 (3) Maternity benefits, including cost of delivery and prenatal care;
- 25 (4) Out-of-hospital physical examination, including related
26 **[X-rays]** appropriate diagnostic imaging and other diagnostic tests, on
27 the following basis:
- 28 (a) For covered minors of less than two years of age, up to six
29 examinations during the first two years of life; for covered minors of
30 two years of age or older, one examination at age 3, 6, 9, 12, 15 and
31 18 years;
- 32 (b) For covered adults of less than 40 years of age, one
33 examination every five years; for covered adults 40 or more years of
34 age but less than 60 years of age, one examination every three years;
35 and for covered adults 60 years of age or older, one examination every
36 two years.
- 37 Notwithstanding the provisions of this section to the contrary, a
38 health service corporation may provide alternative benefits or services
39 from those required by this subsection if they are approved by the
40 Commissioner of Insurance and are within the intent of this
41 amendatory and supplementary act.
- 42 b. (1) No person who is eligible for coverage under Medicare
43 pursuant to Pub.L.89-97 (42U.S.C.s.1395 et seq.) shall be a covered
44 person under a contract required to be offered pursuant to section 54
45 of P.L.1991, c.187 (C.17:48E-22.1).
- 46 (2) A health service corporation shall not sell a contract required

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

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

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

17 d. Notwithstanding any other law to the contrary, a health service
18 corporation shall file copies of all forms of contracts required to be
19 offered pursuant to section 54 of P.L.1991, c.187 (C.17:48E-22.1) for
20 approval with the Commissioner of Banking and Insurance at least 60
21 days prior to becoming effective. Unless disapproved by the
22 commissioner prior to its effective date specifying in what respects the
23 form is not in compliance with the standards set forth in this
24 subsection, any such contract form filed with the commissioner shall
25 be deemed approved as of its effective date, provided, however, that
26 contract forms shall be effective only with respect to those contract
27 form filings which are accompanied by an explanation and
28 identification of the changes being made on a form prescribed by the
29 commissioner. In his discretion, the commissioner may waive the
30 60-day waiting period or any portion thereof.

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

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

46 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

27 (cf: P.L.1991, c.187, s.55)]¹

28

29 ¹[5.] 3.¹ a. No group or individual health service corporation
30 contract providing hospital or medical benefits shall be delivered,
31 issued, executed or renewed in this State pursuant to P.L.1985, c.236
32 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State
33 by the Commissioner of Banking and Insurance on or after the
34 effective date of this amendatory and supplementary act, unless the
35 contract provides benefits to any person covered thereunder who is
36 severely disabled or a child age five or under for expenses incurred for:
37 (1) general anesthesia and hospitalization for dental services; or (2) a
38 medical condition covered by the contract which requires
39 hospitalization or general anesthesia for dental services rendered by a
40 dentist regardless of where the dental services are provided.

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

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

1 reserved the right to change the premium.

2

3 ¹[6.]4.¹ a. No individual health insurance policy providing
4 hospital or medical benefits shall be delivered, issued, executed or
5 renewed in this State pursuant to chapter 26 of Title 17B of the New
6 Jersey Statutes, or approved for issuance or renewal in this State by
7 the Commissioner of Banking and Insurance on or after the effective
8 date of this amendatory and supplementary act, unless the policy
9 provides benefits to any person covered thereunder who is severely
10 disabled or a child age five or under for expenses incurred for: (1)
11 general anesthesia and hospitalization for dental services; or (2) a
12 medical condition covered by the contract which requires
13 hospitalization or general anesthesia for dental services rendered by a
14 dentist regardless of where the dental services are provided.

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

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

21

22 ¹[7.]5.¹ a. No group health insurance policy providing hospital
23 or medical benefits shall be delivered, issued, executed or renewed in
24 this State pursuant to chapter 27 of Title 17B of the New Jersey
25 Statutes, or approved for issuance or renewal in this State by the
26 Commissioner of Banking and Insurance on or after the effective date
27 of this amendatory and supplementary act, unless the policy provides
28 benefits to any person covered thereunder who is severely disabled or
29 a child age five or under for expenses incurred for: (1) general
30 anesthesia and hospitalization for dental services; or (2) a medical
31 condition covered by the contract which requires hospitalization or
32 general anesthesia for dental services rendered by a dentist regardless
33 of where the dental services are provided.

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

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

40

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

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

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

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

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

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

9 (c) Hospital outpatient services consisting of hospital services on
10 the day surgery is performed; hospital services rendered within
11 72 hours after accidental injury; and **[X-ray]** appropriate diagnostic
12 imaging and **[laboratory]** clinical tests to the extent that benefits for
13 such services would have been provided if rendered to an inpatient of
14 the hospital;

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

17 (a) Surgical services;

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

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

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

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

29 (a) For enrollees who are less than two years of age, up to six
30 examinations during the first two years of life; for enrollees who are
31 minors of two years of age or older, one examination at age 3, 6, 9,
32 12, 15 and 18 years;

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

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

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

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

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

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

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

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

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

42 Rates shall not be excessive, inadequate or unfairly discriminatory.

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

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

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

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

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

31 (cf: P.L.1995, c.73, s.27)]¹

32
33 ¹[9.] 6.¹ a. A certificate of authority to establish and operate a
34 health maintenance organization in this State pursuant to P.L.1973,
35 c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the
36 Commissioner of Health and Senior Services on or after the effective
37 date of this amendatory and supplementary act unless the health
38 maintenance organization provides health care services to an enrollee
39 who is severely disabled or a child age five or under for: (1) general
40 anesthesia and hospitalization for dental services; or (2) a medical
41 condition covered by the enrollee agreement which requires
42 hospitalization or general anesthesia for dental services rendered by a
43 participating dentist regardless of where the dental services are
44 provided.

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

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

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

6

7 ¹~~10.~~ 7.¹ This act shall take effect 90 days following enactment.

Office of the Governor
NEWS RELEASE

CONTACT: Gene Herman
609-777-2600

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.