CHAPTER 353
(CORRECTED COPY)

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

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

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

C.17:48-6e Hospital service corporation insurance benefits for preexisting condition.

2. a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group. A hospital service corporation shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

C.17:48A-7d Medical service corporation insurance benefits for preexisting condition.

1. a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a medical service corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group. A medical service corporation shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

C.17:48E-35.2 Health service corporation insurance benefits for preexisting condition.

3. a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a health service corporation pursuant to the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group. A health service corporation shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

C.17B:27A-7 Approval of policy and contract forms, benefit levels.

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

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

b. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting condition limitation of any period and shall not include a preexisting condition as a factor in calculating the premium.

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

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

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

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

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

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

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

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

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

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

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

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

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

C.17B:27A-22 Preexisting condition provisions.

6. a. No health benefits plan subject to this act shall include any provision excluding coverage for a preexisting condition regardless of the cause of the condition.

b. (Deleted by amendment, P.L.2019, c.353)

c. (Deleted by amendment, P.L.2019, c.353)

C.26:2S-34 Preexisting condition provision prohibited in health benefits plan.

6. A carrier that offers a health benefits plan in this State shall ensure that the plan does not contain any provision that:

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

b. uses a preexisting condition as a factor in calculating a premium.

Repealer.

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

8. This act shall take effect immediately.

Approved January 16, 2020.