ASSEMBLY, No. 3976

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED DECEMBER 6, 2001

Sponsored by:
Assemblyman JOSEPH PENNACCHIO
District 26 (Essex, Morris and Passaic)

Co-Sponsored by:
Assemblyman Corodemus

SYNOPSIS
Mandates health insurance coverage for certain infant formulas.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 1/4/2002)

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

1. (New section) A hospital service corporation which provides hospital or medical expense benefits for expenses incurred in the purchase of prescription drugs under a contract that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits under the contract 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 contract.

   This section shall apply to those hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

2. (New section) A medical service corporation which provides hospital or medical expense benefits for expenses incurred in the purchase of prescription drugs under a contract that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits under the contract 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

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

Matter underlined thus is new matter.
prescribed items under the contract.

This section shall apply to those medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

3. (New section) A health service corporation which provides hospital or medical expense benefits for expenses incurred in the purchase of prescription drugs under a contract that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits under the contract 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 contract.

This section shall apply to those health service corporation contracts in which the health service corporation has reserved the right to change the premium.

4. (New section) A group health insurer which provides hospital or medical expense benefits for expenses incurred in the purchase of prescription drugs under a policy that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits under the policy 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 policy.

This section shall apply to those policies in which the insurer has reserved the right to change the premium.

5. (New section) An individual health insurer which provides hospital or medical expense benefits for expenses incurred in the
purchase of prescription drugs under a policy that is delivered, issued, 
executed or renewed in this State, or approved for issuance or renewal 
in this State by the Commissioner of Banking and Insurance on or after 
the effective date of this act, shall provide benefits under the policy 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 policy. 
This section shall apply to those policies in which the insurer has 
reserved the right to change the premium. 

6. (New section) A certificate of authority to establish and operate 
a health maintenance organization in this State shall not be issued or 
continued on or after the effective date of this act for a health 
maintenance organization that provides health care services for 
prescription drugs under a contract, unless the health maintenance 
organization also provides health care services in the purchase of 
specialized non-standard infant formulas, when the covered infant's 
physician has diagnosed the infant as having multiple food protein 
tolerance 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 health care services shall be provided to the same extent as for 
any other prescribed items under the contract. 
The provisions of this section shall apply to those contracts for 
health care services by health maintenance organizations under which 
the health maintenance organization has reserved the right to change 
the schedule of charges for enrollee coverage. 

7. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read 
as follows: 
6. The board shall establish 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, 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 board shall provide the commissioner with an informational filing of the policy and contract forms and benefit levels it establishes.

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

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

1. to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or
2. to a federally defined eligible individual who applies for an individual health benefits plan within 63 days of termination of the prior coverage.

c. In addition to the five 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 board and certify to the board that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding board approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the board of the certification, the certified plans may be used until the board, 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.1995, c.316 (C.17:48E-35.10 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.1995, c.316 (C.17:48E-35.10 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 and Senior Services 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 and Senior Services 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.

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall 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.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L. , c. (pending before the Legislature as this bill) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L. , c. (pending before the Legislature as this bill), 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.

(cf: P.L.1997, c.414, s.1)
8. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to read as follows:

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer the five health benefit plans as provided in this section. The board shall establish a standard policy form for each of the five plans, which except as otherwise provided in subsection j. of this section, shall be the only plans offered to small groups on or after January 1, 1994. One policy form shall contain the benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity carriers, one policy form shall be established which contains benefits and cost sharing levels which are equivalent to the health benefits plans of health maintenance organizations pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

(1) Basic inpatient and outpatient hospital care;
(2) Basic and extended medical-surgical benefits;
(3) Diagnostic tests, including X-rays;
(4) Maternity benefits, including prenatal and postnatal care; and
(5) Preventive medicine, including periodic physical examinations and inoculations.

At least three of the forms shall provide for major medical benefits in varying lifetime aggregates, one of which shall provide at least $1,000,000 in lifetime aggregate benefits. The policy forms provided pursuant to this section shall contain benefits representing progressively greater actuarial values.

Notwithstanding the provisions of this subsection to the contrary, the board also may establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through a dual arrangement with the health maintenance organization. The dual arrangement shall be filed with the commissioner for approval. The additional policy forms shall be consistent with the general requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).

b. Initially, a carrier shall offer a plan within 90 days of the approval of such plan by the commissioner. Thereafter, the plans shall be available to all small employers on a continuing basis. Every small employer which elects to be covered under any health benefits plan who pays the premium therefor and who satisfies the participation requirements of the plan shall be issued a policy or contract by the carrier.

c. The carrier may establish a premium payment plan which provides installment payments and which may contain reasonable
provisions to ensure payment security, provided that provisions to
effect payment security are uniformly applied.
d. In addition to the five standard policies described in subsection
a. of this section, the board may develop up to five rider packages.
Any such package which a carrier chooses to offer shall be issued to
a small employer who pays the premium therefor, and shall be subject
to the rating methodology set forth in section 9 of P.L.1992, c.162
(C.17B:27A-25).
e. Notwithstanding the provisions of subsection a. of this section
to the contrary, the board may approve a health benefits plan
containing only medical-surgical benefits or major medical expense
benefits, or a combination thereof, which is issued as a separate policy
in conjunction with a contract of insurance for hospital expense
benefits issued by a hospital service corporation, if the health benefits
plan and hospital service corporation contract combined otherwise
comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et
seq.). Deductibles and coinsurance limits for the contract combined
may be allocated between the separate contracts at the discretion of
the carrier and the hospital service corporation.
f. Notwithstanding the provisions of this section to the contrary,
a health maintenance organization which is a qualified health
maintenance organization pursuant to the "Health Maintenance
shall be permitted to offer health benefits plans formulated by the
board and approved by the commissioner which are in accordance with
the provisions of that law in lieu of the five plans required pursuant to
this section.
Notwithstanding the provisions of this section to the contrary, a
health maintenance organization which is approved pursuant to
P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
benefits plans formulated by the board and approved by the
commissioner which are in accordance with the provisions of that law
in lieu of the five plans required pursuant to this section, except that
the plans shall provide the same level of benefits as required for a
federally qualified health maintenance organization, including any
requirements concerning copayments by enrollees.
g. A carrier shall not be required to own or control a health
maintenance organization or otherwise affiliate with a health
maintenance organization in order to comply with the provisions of
this section, but the carrier shall be required to offer the five health
benefits plans which are formulated by the board and approved by the
commissioner, including one plan which contains benefits and cost
sharing levels that are equivalent to those required for health
maintenance organizations.
h. Notwithstanding the provisions of subsection a. of this section
to the contrary, the board may modify the benefits provided for in

i. (1) In addition to the rider packages provided for in subsection d.

of this section, every carrier may offer, in connection with the five

health benefits plans required to be offered by this section, any number

of riders which may revise the coverage offered by the five plans in

any way, provided, however, that any form of such rider or

amendment thereof which decreases benefits or decreases the actuarial

value of one of the five plans shall be filed for informational purposes

with the board and for approval by the commissioner before such rider

may be sold. Any rider or amendment thereof which adds benefits or

increases the actuarial value of one of the five plans shall be filed with

the board for informational purposes before such rider may be sold.

The commissioner shall disapprove any rider filed pursuant to this

subsection that is unjust, unfair, inequitable, unreasonably
discriminatory, misleading, contrary to law or the public policy of this
State. The commissioner shall not approve any rider which reduces
benefits below those required by sections 55, 57 and 59 of P.L. 1991,
c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be
sold pursuant to this section. The commissioner's determination shall
be in writing and shall be appealable.

(2) The benefit riders provided for in paragraph (1) of this
subsection shall be subject to the provisions of section 2, subsection
b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L. 1992, c.162

j. (1) Notwithstanding the provisions of P.L. 1992, c.162
(C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
by or through a carrier, association, multiple employer arrangement
prior to January 1, 1994 or, if the requirements of subparagraph (c) of
paragraph (6) of this subsection are met, issued by or through an
out-of-State trust prior to January 1, 1994, at the option of a small
employer policy or contract holder, may be renewed or continued after
February 28, 1994, or in the case of such a health benefits plan whose
anniversary date occurred between March 1, 1994 and the effective
date of P.L. 1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
within 60 days of that anniversary date and renewed or continued if,
beginning on the first 12-month anniversary date occurring on or after
the sixtieth day after the board adopts regulations concerning the
implementation of the rating factors permitted by section 9 of
P.L. 1992, c.162 (C.17B:27A-25) and, regardless of the situs of
delivery of the health benefits plan, the health benefits plan renewed,
continued or reinstated pursuant to this subsection complies with the
provisions of section 2, subsection b. of section 3, and sections 6, 7,
Nothing in this subsection shall be construed to require an association, multiple employer arrangement or out-of-State trust to provide health benefits coverage to small employers that are not contemplated by the organizational documents, bylaws, or other regulations governing the purpose and operation of the association, multiple employer arrangement or out-of-State trust. Notwithstanding the foregoing provision to the contrary, an association, multiple employer arrangement or out-of-State trust that offers health benefits coverage to its members' employees and dependents:

(a) shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust;

(b) shall not use actual or expected health status in determining its membership; and

(c) shall make available to its small employer members at least one of the standard benefits plans, as determined by the commissioner, in addition to any health benefits plan permitted to be renewed or continued pursuant to this subsection.

(2) Notwithstanding the provisions of this subsection to the contrary, a carrier or out-of-State trust which writes the health benefits plans required pursuant to subsection a. of this section shall be required to offer those plans to any small employer, association or multiple employer arrangement.

(3) (a) A carrier, association, multiple employer arrangement or out-of-State trust may withdraw a health benefits plan marketed to small employers that was in effect on December 31, 1993 with the approval of the commissioner. The commissioner shall approve a request to withdraw a plan, consistent with regulations adopted by the commissioner, only on the grounds that retention of the plan would cause an unreasonable financial burden to the issuing carrier, taking into account the rating provisions of section 9 of P.L.1992, c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

(b) A carrier which has renewed, continued or reinstated a health benefits plan pursuant to this subsection that has not been newly issued to a new small employer group since January 1, 1994, may, upon approval of the commissioner, continue to establish its rates for that plan based on the loss experience of that plan if the carrier does not issue that health benefits plan to any new small employer groups.


(5) A health benefits plan that otherwise conforms to the requirements of this subsection shall be deemed to be in compliance with this subsection, notwithstanding any change in the plan's deductible or copayment.

(6) (a) Except as otherwise provided in subparagraphs (b) and (c)
of this paragraph, a health benefits plan renewed, continued or reinstated pursuant to this subsection shall be filed with the commissioner for informational purposes within 30 days after its renewal date. No later than 60 days after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be amended to show any modifications in the plan that are necessary to comply with the provisions of this subsection. The commissioner shall monitor compliance of any such plan with the requirements of this subsection, except that the board shall enforce the loss ratio requirements.

(b) A health benefits plan filed with the commissioner pursuant to subparagraph (a) of this paragraph may be amended as to its benefit structure if the amendment does not reduce the actuarial value and benefits coverage of the health benefits plan below that of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. The amendment shall be filed with the commissioner for approval pursuant to the terms of sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

c) A health benefits plan issued by a carrier through an out-of-State trust shall be permitted to be renewed or continued pursuant to paragraph (1) of this subsection upon approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.

(7) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, an association, multiple employer arrangement or out-of-State trust may offer a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to small employer groups that are otherwise eligible pursuant to paragraph (1) of subsection j. of this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.
(8) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple employer arrangement or out-of-State trust may offer coverage under a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to new employees of small employer groups covered by the health benefits plan in accordance with the provisions of paragraph (1) of this subsection.

(9) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, any individual, who is eligible for small employer coverage under a policy issued, renewed, continued or reinstated pursuant to this subsection, but who would be subject to a preexisting condition exclusion under the small employer health benefits plan, or who is a member of a small employer group who has been denied coverage under the small employer group health benefits plan for health reasons, may elect to purchase or continue coverage under an individual health benefits plan until such time as the group health benefits plan covering the small employer group of which the individual is a member complies with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(10) In a case in which an association made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of P.L.1995, c.340, the new issuing carrier shall be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of this subsection.

(11) In a case in which an association, multiple employer arrangement or out-of-State trust made available a health benefits plan on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

(12) In a case in which a small employer purchased a health benefits plan directly from a carrier on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

Notwithstanding the provisions of subparagraph (b) of paragraph (6) of this subsection to the contrary, a small employer who changes its health benefits plan's issuing carrier pursuant to the provisions of this paragraph, shall not, upon changing carriers, modify the benefit structure of that health benefits plan within six months of the date the issuing carrier was changed.
k. Effective immediately for a health benefits plan issued on or after the effective date of P.L.1995, c.316 (C.17:48E-35.10 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.1995, c.316 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to this section, including any plans offered by a State approved or 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 and Senior Services 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 immunization as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health and Senior Services 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.

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this [section] subsection. This [section] subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

l. The board shall consider including benefits for speech-language pathology and audiology services, as rendered by speech-language pathologists and audiologists within the scope of their practices, in at least one of the five standard policies and in at least one of the five riders to be developed under this section.

m. Effective immediately for a health benefits plan issued on or after the effective date of P.L. (pending before the Legislature as this bill) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L. (pending before the Legislature as this bill), the health benefits plans required pursuant to this section 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 small employer health benefits
plans in which the carrier has reserved the right to change the
premium.

(cf: P.L.1997, c.419, s.6)

9. This act shall take effect on the 60th day following enactment.

STATEMENT

This bill requires hospital, medical and health service corporations,
individual, small employer and large group insurers and health
maintenance organizations to provide coverage for certain specialized
infant formulas. Infants who suffer from multiple food protein
intolerance and are not responsive to standard non-cow milk-based
formulas require specialty formulas. The cost of these specialty
formulas, such as Neocate, is more than two and a half times the
average cost of standard infant formulas. Although these specialty
formulas are only administered under a physician’s supervision, they
are not classified as prescription drugs.