

# ASSEMBLY, No. 3440

## STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED OCTOBER 25, 2004

**Sponsored by:**

**Assemblyman NEIL M. COHEN**

**District 20 (Union)**

**Assemblyman DAVID C. RUSSO**

**District 40 (Bergen, Essex and Passaic)**

**Co-Sponsored by:**

**Assemblyman Prieto**

**SYNOPSIS**

Provides for establishment of health savings accounts.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 5/13/2005)**

A3440 COHEN, RUSSO

2

1 AN ACT concerning health savings accounts and amending P.L.1995,  
2 c.316, P.L. 1992, c.161 and P.L. 1992, c.162.

3

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

6

7 1. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to  
8 read as follows:

9 1. No health service corporation contract providing hospital or  
10 medical expense benefits for groups with greater than 50 persons shall  
11 be delivered, issued, executed or renewed in this State, or approved  
12 for issuance or renewal in this State by the Commissioner of Banking  
13 and Insurance on or after the effective date of this act, unless the  
14 contract provides benefits to any named subscriber or other person  
15 covered thereunder for expenses incurred in the following:

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

21 b. All childhood immunizations as recommended by the Advisory  
22 Committee on Immunization Practices of the United States Public  
23 Health Service and the Department of Health and Senior Services  
24 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health  
25 service corporation shall notify its subscribers, in writing, of any  
26 change in coverage with respect to childhood immunizations and any  
27 related changes in premium. Such notification shall be in a form and  
28 manner to be determined by the Commissioner of Banking and  
29 Insurance.

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

37 The benefits shall be provided to the same extent as for any other  
38 medical condition under the contract, except that no deductible shall  
39 be applied for benefits provided pursuant to this section; provided,  
40 however, that with respect to a contract that is a high deductible  
41 health plan issued in conjunction with a health savings account  
42 established pursuant to section 223 of the federal Internal Revenue  
43 Code of 1986 (26 U.S.C. s.223), a deductible may be applied. This

**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 section shall apply to all health service corporation contracts in which  
2 the health service corporation has reserved the right to change the  
3 premium.

4 (cf: P.L.2001, c.373, s.10)

5

6 2. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read  
7 as follows:

8 2. No hospital service corporation contract providing hospital or  
9 medical expense benefits for groups with greater than 50 persons shall  
10 be delivered, issued, executed or renewed in this State, or approved  
11 for issuance or renewal in this State by the Commissioner of Banking  
12 and Insurance on or after the effective date of this act, unless the  
13 contract provides benefits to any named subscriber or other person  
14 covered thereunder for expenses incurred in the following:

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

20 b. All childhood immunizations as recommended by the Advisory  
21 Committee on Immunization Practices of the United State Public  
22 Health Service and the Department of Health and Senior Services  
23 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital  
24 service corporation shall notify its subscribers, in writing, of any  
25 change in coverage with respect to childhood immunizations and any  
26 related changes in premium. Such notification shall be in a form and  
27 manner to be determined by the Commissioner of Banking and  
28 Insurance.

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

36 The benefits shall be provided to the same extent as for any other  
37 medical condition under the contract, except that no deductible shall  
38 be applied for benefits provided pursuant to this section; provided,  
39 however, that with respect to a contract that is a high deductible  
40 health plan issued in conjunction with a health savings account  
41 established pursuant to section 223 of the federal Internal Revenue  
42 Code of 1986 (26 U.S.C. s.223), a deductible may be applied. This  
43 section shall apply to all hospital service corporation contracts in  
44 which the hospital service corporation has reserved the right to change  
45 the premium.

46 (cf: P.L.2001, c.373, s.11)

1       3. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) is amended to  
2 read as follows:

3       3. No group health insurance policy providing hospital or medical  
4 expense benefits for groups with more than 50 persons shall be  
5 delivered, issued, executed or renewed in this State, or approved for  
6 issuance or renewal in this State by the Commissioner of Banking and  
7 Insurance on or after the effective date of this act, unless the policy  
8 provides benefits to any named insured or other person covered  
9 thereunder for expenses incurred in the following:

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

15       b. All childhood immunizations as recommended by the Advisory  
16 Committee on Immunization Practices of the United States Public  
17 Health Service and the Department of Health and Senior Services  
18 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health  
19 insurer shall notify its policyholders, in writing, of any change in  
20 coverage with respect to childhood immunizations and any related  
21 changes in premium. Such notification shall be in a form and manner  
22 to be determined by the Commissioner of Banking and Insurance.

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

30       The benefits shall be provided to the same extent as for any other  
31 medical condition under the policy, except that no deductible shall be  
32 applied for benefits provided pursuant to this section; provided,  
33 however, that with respect to a policy that is a high deductible health  
34 plan issued in conjunction with a health savings account established  
35 pursuant to section 223 of the federal Internal Revenue Code of 1986  
36 (26 U.S.C. s.223), a deductible may be applied. This section shall  
37 apply to all group health insurance policies in which the health insurer  
38 has reserved the right to change the premium.

39 (cf: P.L.2001, c.373, s.12)

40

41       4. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to read  
42 as follows:

43       4. A certificate of authority to establish and operate a health  
44 maintenance organization in this State shall not be issued or continued  
45 by the Commissioner of Health and Senior Services on or after the  
46 effective date of this act unless the health maintenance organization

1 offers health care services to any enrollee which include:

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

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

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

23 The health care services shall be provided to the same extent as for  
24 any other medical condition under the contract, except that no  
25 deductible shall be applied for services provided pursuant to this  
26 section; provided, however, that with respect to a contract that is a  
27 high deductible health plan issued in conjunction with a health savings  
28 account established pursuant to section 223 of the federal Internal  
29 Revenue Code of 1986 (26 U.S.C. s.223), a deductible may be applied.  
30 This section shall apply to all contracts under which the health  
31 maintenance organization has reserved the right to change the schedule  
32 of charges for enrollee coverage.

33 (cf: P.L.2001, c.373, s.13)

34

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

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

1 informational filing of the policy and contract forms and benefit levels  
2 it establishes.

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

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

17 (1) to an individual who has, under creditable coverage, with no  
18 intervening lapse in coverage of more than 31 days, been treated or  
19 diagnosed by a physician for a condition under that plan or satisfied a  
20 12-month preexisting condition limitation; or

21 (2) to a federally defined eligible individual who applies for an  
22 individual health benefits plan within 63 days of termination of the  
23 prior coverage.

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

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

39 e. Effective immediately for an individual health benefits plan  
40 issued on or after the effective date of P.L.1995, c.316  
41 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary  
42 date of an individual health benefits plan in effect on the effective date  
43 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health  
44 benefits plans required pursuant to section 3 of P.L.1992, c.161  
45 (C.17B:27A-4), including any plan offered by a federally qualified  
46 health maintenance organization, shall contain benefits for expenses

1 incurred in the following:

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

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

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

23 The benefits shall be provided to the same extent as for any other  
24 medical condition under the health benefits plan, except that no  
25 deductible shall be applied for benefits provided pursuant to this  
26 subsection; provided, however, that with respect to a health benefits  
27 plan that is a high deductible health plan issued in conjunction with a  
28 health savings account established pursuant to section 223 of the  
29 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible  
30 may be applied. This subsection shall apply to all individual health  
31 benefits plans in which the carrier has reserved the right to change the  
32 premium.

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

1 necessity of the specialized infant formula.

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

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

6 (cf: P.L.2001, c.373, s.14)

7

8 6. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
9 read as follows:

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

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

31 At least three of the forms shall provide for major medical benefits  
32 in varying lifetime aggregates, one of which shall provide at least  
33 \$1,000,000 in lifetime aggregate benefits. The policy forms provided  
34 pursuant to this section shall contain benefits representing  
35 progressively greater actuarial values.

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

45 b. Initially, a carrier shall offer a plan within 90 days of the  
46 approval of such plan by the commissioner. Thereafter, the plans shall

1 be available to all small employers on a continuing basis. Every small  
2 employer which elects to be covered under any health benefits plan  
3 who pays the premium therefor and who satisfies the participation  
4 requirements of the plan shall be issued a policy or contract by the  
5 carrier.

6 c. The carrier may establish a premium payment plan which  
7 provides installment payments and which may contain reasonable  
8 provisions to ensure payment security, provided that provisions to  
9 ensure payment security are uniformly applied.

10 d. In addition to the five standard policies described in subsection  
11 a. of this section, the board may develop up to five rider packages.  
12 Any such package which a carrier chooses to offer shall be issued to  
13 a small employer who pays the premium therefor, and shall be subject  
14 to the rating methodology set forth in section 9 of P.L.1992, c.162  
15 (C.17B:27A-25).

16 e. Notwithstanding the provisions of subsection a. of this section  
17 to the contrary, the board may approve a health benefits plan  
18 containing only medical-surgical benefits or major medical expense  
19 benefits, or a combination thereof, which is issued as a separate policy  
20 in conjunction with a contract of insurance for hospital expense  
21 benefits issued by a hospital service corporation, if the health benefits  
22 plan and hospital service corporation contract combined otherwise  
23 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et  
24 seq.). Deductibles and coinsurance limits for the contract combined  
25 may be allocated between the separate contracts at the discretion of  
26 the carrier and the hospital service corporation.

27 f. Notwithstanding the provisions of this section to the contrary,  
28 a health maintenance organization which is a qualified health  
29 maintenance organization pursuant to the "Health Maintenance  
30 Organization Act of 1973," Pub.L.93-222 (42 U.S.C.s.300e et seq.)  
31 shall be permitted to offer health benefits plans formulated by the  
32 board and approved by the commissioner which are in accordance with  
33 the provisions of that law in lieu of the five plans required pursuant to  
34 this section.

35 Notwithstanding the provisions of this section to the contrary, a  
36 health maintenance organization which is approved pursuant to  
37 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health  
38 benefits plans formulated by the board and approved by the  
39 commissioner which are in accordance with the provisions of that law  
40 in lieu of the five plans required pursuant to this section, except that  
41 the plans shall provide the same level of benefits as required for a  
42 federally qualified health maintenance organization, including any  
43 requirements concerning copayments by enrollees.

44 g. A carrier shall not be required to own or control a health  
45 maintenance organization or otherwise affiliate with a health  
46 maintenance organization in order to comply with the provisions of

1 this section, but the carrier shall be required to offer the five health  
2 benefits plans which are formulated by the board and approved by the  
3 commissioner, including one plan which contains benefits and cost  
4 sharing levels that are equivalent to those required for health  
5 maintenance organizations.

6 h. Notwithstanding the provisions of subsection a. of this section  
7 to the contrary, the board may modify the benefits provided for in  
8 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2  
9 and 26:2J-4.3).

10 i. (1) In addition to the rider packages provided for in subsection  
11 d. of this section, every carrier may offer, in connection with the five  
12 health benefits plans required to be offered by this section, any number  
13 of riders which may revise the coverage offered by the five plans in  
14 any way, provided, however, that any form of such rider or  
15 amendment thereof which decreases benefits or decreases the actuarial  
16 value of one of the five plans shall be filed for informational purposes  
17 with the board and for approval by the commissioner before such rider  
18 may be sold. Any rider or amendment thereof which adds benefits or  
19 increases the actuarial value of one of the five plans shall be filed with  
20 the board for informational purposes before such rider may be sold.

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

29 (2) The benefit riders provided for in paragraph (1) of this  
30 subsection shall be subject to the provisions of section 2, subsection  
31 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162  
32 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23,  
33 17B:27A-24, 17B:27A-25, and 17B:27A-27).

34 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
35 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
36 by or through a carrier, association, or multiple employer arrangement  
37 prior to January 1, 1994 or, if the requirements of subparagraph (c) of  
38 paragraph (6) of this subsection are met, issued by or through an  
39 out-of-State trust prior to January 1, 1994, at the option of a small  
40 employer policy or contract holder, may be renewed or continued after  
41 February 28, 1994, or in the case of such a health benefits plan whose  
42 anniversary date occurred between March 1, 1994 and the effective  
43 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated  
44 within 60 days of that anniversary date and renewed or continued if,  
45 beginning on the first 12-month anniversary date occurring on or after  
46 the sixtieth day after the board adopts regulations concerning the

1 implementation of the rating factors permitted by section 9 of  
2 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of  
3 delivery of the health benefits plan, the health benefits plan renewed,  
4 continued or reinstated pursuant to this subsection complies with the  
5 provisions of section 2, subsection b. of section 3, and sections 6, 7,  
6 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19,  
7 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and  
8 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

9 Nothing in this subsection shall be construed to require an  
10 association, multiple employer arrangement or out-of-State trust to  
11 provide health benefits coverage to small employers that are not  
12 contemplated by the organizational documents, bylaws, or other  
13 regulations governing the purpose and operation of the association,  
14 multiple employer arrangement or out-of-State trust. Notwithstanding  
15 the foregoing provision to the contrary, an association, multiple  
16 employer arrangement or out-of-State trust that offers health benefits  
17 coverage to its members' employees and dependents:

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

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

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

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

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

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

1 (4) (Deleted by amendment, P.L.1995, c.340).

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

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

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

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

44 (7) Notwithstanding the provisions of P.L.1992, c.162  
45 (C.17B:27A-17 et seq.) to the contrary, an association, multiple  
46 employer arrangement or out-of-State trust may offer a health benefits

1 plan authorized to be renewed, continued or reinstated pursuant to this  
2 subsection to small employer groups that are otherwise eligible  
3 pursuant to paragraph (1) of subsection j. of this section during the  
4 period for which such health benefits plan is otherwise authorized to  
5 be renewed, continued or reinstated.

6 (8) Notwithstanding the provisions of P.L.1992, c.162  
7 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple  
8 employer arrangement or out-of-State trust may offer coverage under  
9 a health benefits plan authorized to be renewed, continued or  
10 reinstated pursuant to this subsection to new employees of small  
11 employer groups covered by the health benefits plan in accordance  
12 with the provisions of paragraph (1) of this subsection.

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

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

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

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

46 Notwithstanding the provisions of subparagraph (b) of paragraph

1 (6) of this subsection to the contrary, a small employer who changes  
2 its health benefits plan's issuing carrier pursuant to the provisions of  
3 this paragraph, shall not, upon changing carriers, modify the benefit  
4 structure of that health benefits plan within six months of the date the  
5 issuing carrier was changed.

6 k. Effective immediately for a health benefits plan issued on or  
7 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and  
8 effective on the first 12-month anniversary date of a health benefits  
9 plan in effect on the effective date of P.L.1995, c.316  
10 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to  
11 this section, including any plans offered by a State approved or  
12 federally qualified health maintenance organization, shall contain  
13 benefits for expenses incurred in the following:

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

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

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

35 The benefits shall be provided to the same extent as for any other  
36 medical condition under the health benefits plan, except that no  
37 deductible shall be applied for benefits provided pursuant to this  
38 subsection; provided, however, that with respect to a health benefits  
39 plan that is a high deductible health plan issued in conjunction with a  
40 health savings account established pursuant to section 223 of the  
41 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible  
42 may be applied. This subsection shall apply to all small employer  
43 health benefits plans in which the carrier has reserved the right to  
44 change the premium.

45 1. The board shall consider including benefits for speech-language  
46 pathology and audiology services, as rendered by speech-language

1 pathologists and audiologists within the scope of their practices, in at  
2 least one of the five standard policies and in at least one of the five  
3 riders to be developed under this section.

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

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

21 This subsection shall apply to all small employer health benefits  
22 plans in which the carrier has reserved the right to change the  
23 premium.

24 (cf: P.L.2001, c.373, s.15)

25

26 7. This act shall take effect on the 30th day after enactment and  
27 shall apply to all contracts and policies that are delivered, issued,  
28 executed or renewed or approved for issuance or renewal in this State  
29 on or after the effective date.

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#### STATEMENT

33

34 This bill facilitates the establishment of health savings accounts in  
35 this State. The federal "Medicare Prescription Drug, Improvement  
36 and Modernization Act of 2003," (Pub. L. 108-173) allows eligible  
37 individuals to establish health savings accounts beginning January 1,  
38 2004. Contributions to health savings accounts receive favorable tax  
39 treatment in that they may be accumulated over the years, or  
40 distributed on a tax-free basis, to pay or reimburse qualifying medical  
41 expenses. To establish such an account, an individual must be enrolled  
42 in a high deductible health plan as defined in the federal law.

43 However, because of the requirements of the federal law, current  
44 provisions of existing State law, which require that certain non-  
45 preventive care or treatment under health insurance contracts and  
46 policies be provided without the application of a deductible, must be

1 modified in order that health savings accounts may be continuously  
2 offered in this State after December 31, 2005. The federal law  
3 provides the states with a two-year transition period, in order to  
4 accomplish any necessary modifications in State law to allow for the  
5 establishment and continuation of health savings accounts.