

ASSEMBLY, No. 2302

STATE OF NEW JERSEY 213th LEGISLATURE

INTRODUCED FEBRUARY 26, 2008

Sponsored by:

Assemblyman PATRICK J. DIEGNAN, JR.

District 18 (Middlesex)

Assemblyman UPENDRA J. CHIVUKULA

District 17 (Middlesex and Somerset)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

Co-Sponsored by:

Assemblywoman Lampitt and Assemblyman Coutinho

SYNOPSIS

Requires health insurers to provide coverage for certain infant formulas.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 12/9/2008)

1 AN ACT concerning coverage of certain infant formulas and
2 amending P.L.2001, c.361, 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.2001, c.361 (C.17:48-6z) is amended to
8 read as follows:

9 1. A hospital service corporation which provides hospital or
10 medical expense benefits **[for expenses incurred in the purchase of**
11 **prescription drugs]** under a contract that is delivered, issued,
12 executed or renewed in this State, or approved for issuance or
13 renewal in this State by the Commissioner of Banking and
14 Insurance, on or after the effective date of this act, shall provide
15 benefits under the contract for expenses incurred in the purchase of
16 specialized non-standard infant formulas, when the covered infant's
17 physician has diagnosed the infant as having multiple food protein
18 intolerance and has determined such formula to be medically
19 necessary, and when the covered infant has not been responsive to
20 trials of standard non-cow milk-based formulas, including soybean
21 and goat milk. The coverage may be subject to utilization review,
22 including periodic review, of the continued medical necessity of the
23 specialized infant formula.

24 The benefits shall be provided to the same extent as for any other
25 **[prescribed items]** condition under the contract.

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

29 (cf: P.L.2001, c.361, s.1)

30

31 2. Section 2 of P.L.2001, c.361 (C.17:48A-7y) is amended to
32 read as follows:

33 2. A medical service corporation which provides hospital or
34 medical expense benefits **[for expenses incurred in the purchase of**
35 **prescription drugs]** under a contract that is delivered, issued,
36 executed or renewed in this State, or approved for issuance or
37 renewal in this State by the Commissioner of Banking and
38 Insurance, on or after the effective date of this act, shall provide
39 benefits under the contract for expenses incurred in the purchase of
40 specialized non-standard infant formulas, when the covered infant's
41 physician has diagnosed the infant as having multiple food protein
42 intolerance and has determined such formula to be medically
43 necessary, and when the covered infant has not been responsive to
44 trials of standard non-cow milk-based formulas, including soybean
45 and goat milk. The coverage may be subject to utilization review,

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 including periodic review, of the continued medical necessity of the
2 specialized infant formula.

3 The benefits shall be provided to the same extent as for any other
4 **【prescribed items】** condition under the contract.

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

8 (cf: P.L.2001, c.361, s.2)

9

10 3. Section 3 of P.L.2001, c.361 (C.17:48E-35.24) is amended
11 to read as follows:

12 3. A health service corporation which provides hospital or
13 medical expense benefits **【for expenses incurred in the purchase of**
14 **prescription drugs】** under a contract that is delivered, issued,
15 executed or renewed in this State, or approved for issuance or
16 renewal in this State by the Commissioner of Banking and
17 Insurance, on or after the effective date of this act, shall provide
18 benefits under the contract for expenses incurred in the purchase of
19 specialized non-standard infant formulas, when the covered infant's
20 physician has diagnosed the infant as having multiple food protein
21 intolerance and has determined such formula to be medically
22 necessary, and when the covered infant has not been responsive to
23 trials of standard non-cow milk-based formulas, including soybean
24 and goat milk. The coverage may be subject to utilization review,
25 including periodic review, of the continued medical necessity of the
26 specialized infant formula.

27 The benefits shall be provided to the same extent as for any other
28 **【prescribed items】** condition under the contract.

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

32 (cf: P.L.2001, c.361, s.3)

33

34 4. Section 4 of P.L.2001, c.361 (C.17B:27-46.1z) is amended
35 to read as follows:

36 4. A group health insurer which provides hospital or medical
37 expense benefits **【for expenses incurred in the purchase of**
38 **prescription drugs】** under a policy that is delivered, issued,
39 executed or renewed in this State, or approved for issuance or
40 renewal in this State by the Commissioner of Banking and
41 Insurance, on or after the effective date of this act, shall provide
42 benefits under the policy for expenses incurred in the purchase of
43 specialized non-standard infant formulas, when the covered infant's
44 physician has diagnosed the infant as having multiple food protein
45 intolerance and has determined such formula to be medically
46 necessary, and when the covered infant has not been responsive to
47 trials of standard non-cow milk-based formulas, including soybean
48 and goat milk. The coverage may be subject to utilization review,

1 including periodic review, of the continued medical necessity of the
2 specialized infant formula.

3 The benefits shall be provided to the same extent as for any other
4 **【prescribed items】** condition under the policy.

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

7 (cf: P.L.2001, c.361, s.4)

8

9 5. Section 5 of P.L.2001, c.361 (C.17B:26-2.1v) is amended to
10 read as follows:

11 5. An individual health insurer which provides hospital or
12 medical expense benefits **【for expenses incurred in the purchase of**
13 **prescription drugs】** under a policy that is delivered, issued,
14 executed or renewed in this State, or approved for issuance or
15 renewal in this State by the Commissioner of Banking and
16 Insurance, on or after the effective date of this act, shall provide
17 benefits under the policy for expenses incurred in the purchase of
18 specialized non-standard infant formulas, when the covered infant's
19 physician has diagnosed the infant as having multiple food protein
20 intolerance and has determined such formula to be medically
21 necessary, and when the covered infant has not been responsive to
22 trials of standard non-cow milk-based formulas, including soybean
23 and goat milk. The coverage may be subject to utilization review,
24 including periodic review, of the continued medical necessity of the
25 specialized infant formula.

26 The benefits shall be provided to the same extent as for any other
27 **【prescribed items】** condition under the policy.

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

30 (cf: P.L.2001, c.361, s.5)

31

32 6. Section 6 of P.L.2001, c.361 (C.26:2J-4.25) is amended to
33 read as follows:

34 6. A certificate of authority to establish and operate a health
35 maintenance organization in this State shall not be issued or
36 continued on or after the effective date of this act for a health
37 maintenance organization **【that provides health care services for**
38 **prescription drugs under a contract】**, unless the health maintenance
39 organization **【also】** provides health care services **【in】** for
40 the purchase of specialized non-standard infant formulas, when the
41 covered infant's physician has diagnosed the infant as having
42 multiple food protein intolerance and has determined such formula
43 to 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
47 medical necessity of the specialized infant formula.

1 The health care services shall be provided to the same extent as
2 for any other [prescribed items] condition under the contract.

3 The provisions of this section shall apply to those contracts for
4 health care services by health maintenance organizations under
5 which the health maintenance organization has reserved the right to
6 change the schedule of charges for enrollee coverage.

7 (cf: P.L.2001, c.361, s.6)

8

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

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

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

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

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

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

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

1 of P.L.1992, c.161 (C.17B:27A-9).

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

12 e. Effective immediately for an individual health benefits plan
13 issued on or after the effective date of P.L.1995, c.316 (C.17:48E-
14 35.10 et al.) and effective on the first 12-month anniversary date of
15 an individual health benefits plan in effect on the effective date of
16 P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
17 benefits plans required pursuant to section 3 of P.L.1992, c.161
18 (C.17B:27A-4), including any plan offered by a federally qualified
19 health maintenance organization, shall contain benefits for expenses
20 incurred in the following:

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

27 (2) All childhood immunizations as recommended by the
28 Advisory Committee on Immunization Practices of the United
29 States Public Health Service and the Department of Health and
30 Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-
31 137.1). A carrier shall notify its insureds, in writing, of any change
32 in the health care services provided with respect to childhood
33 immunizations and any related changes in premium. Such
34 notification shall be in a form and manner to be determined by the
35 Commissioner of Banking and Insurance.

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

43 The benefits shall be provided to the same extent as for any other
44 medical condition under the health benefits plan, except that no
45 deductible shall be applied for benefits provided pursuant to this
46 subsection. This subsection shall apply to all individual health
47 benefits plans in which the carrier has reserved the right to change
48 the premium.

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

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

21 This subsection shall apply to all individual health benefits plans
22 in which the carrier has reserved the right to change the premium.
23 (cf: P.L.2001, c.373, s.14)

24
25 8. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
26 read as follows:

27 3. a. Except as provided in subsection f. of this section, every
28 small employer carrier shall, as a condition of transacting business
29 in this State, offer to every small employer the five health benefit
30 plans as provided in this section. The board shall establish a
31 standard policy form for each of the five plans, which except as
32 otherwise provided in subsection j. of this section, shall be the only
33 plans offered to small groups on or after January 1, 1994. One
34 policy form shall contain the benefits provided for in sections 55,
35 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and
36 26:2J-4.3). In the case of indemnity carriers, one policy form shall
37 be established which contains benefits and cost sharing levels which
38 are equivalent to the health benefits plans of health maintenance
39 organizations pursuant to the "Health Maintenance Organization
40 Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
41 remaining policy forms shall contain basic hospital and medical-
42 surgical benefits, including, but not limited to:

- 43 (1) Basic inpatient and outpatient hospital care;
- 44 (2) Basic and extended medical-surgical benefits;
- 45 (3) Diagnostic tests, including X-rays;
- 46 (4) Maternity benefits, including prenatal and postnatal care;
- 47 and

1 (5) Preventive medicine, including periodic physical
2 examinations and inoculations.

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

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

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

25 c. The carrier may establish a premium payment plan which
26 provides installment payments and which may contain reasonable
27 provisions to ensure payment security, provided that provisions to
28 ensure payment security are uniformly applied.

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

35 e. Notwithstanding the provisions of subsection a. of this
36 section to the contrary, the board may approve a health benefits
37 plan containing only medical-surgical benefits or major medical
38 expense benefits, or a combination thereof, which is issued as a
39 separate policy in conjunction with a contract of insurance for
40 hospital expense benefits issued by a hospital service corporation, if
41 the health benefits plan and hospital service corporation contract
42 combined otherwise comply with the provisions of P.L.1992, c.162
43 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the
44 contract combined may be allocated between the separate contracts
45 at the discretion of the carrier and the hospital service corporation.

46 f. Notwithstanding the provisions of this section to the
47 contrary, a health maintenance organization which is a qualified
48 health maintenance organization pursuant to the "Health

1 Maintenance Organization Act of 1973," Pub.L.93-222 (42
2 U.S.C.s.300e et seq.) shall be permitted to offer health benefits
3 plans formulated by the board and approved by the commissioner
4 which are in accordance with the provisions of that law in lieu of
5 the five plans required pursuant to this section.

6 Notwithstanding the provisions of this section to the contrary, a
7 health maintenance organization which is approved pursuant to
8 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
9 benefits plans formulated by the board and approved by the
10 commissioner which are in accordance with the provisions of that
11 law in lieu of the five plans required pursuant to this section, except
12 that the plans shall provide the same level of benefits as required
13 for a federally qualified health maintenance organization, including
14 any requirements concerning copayments by enrollees.

15 g. A carrier shall not be required to own or control a health
16 maintenance organization or otherwise affiliate with a health
17 maintenance organization in order to comply with the provisions of
18 this section, but the carrier shall be required to offer the five health
19 benefits plans which are formulated by the board and approved by
20 the commissioner, including one plan which contains benefits and
21 cost sharing levels that are equivalent to those required for health
22 maintenance organizations.

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

27 i. (1) In addition to the rider packages provided for in
28 subsection d. of this section, every carrier may offer, in connection
29 with the five health benefits plans required to be offered by this
30 section, any number of riders which may revise the coverage
31 offered by the five plans in any way, provided, however, that any
32 form of such rider or amendment thereof which decreases benefits
33 or decreases the actuarial value of one of the five plans shall be
34 filed for informational purposes with the board and for approval by
35 the commissioner before such rider may be sold. Any rider or
36 amendment thereof which adds benefits or increases the actuarial
37 value of one of the five plans shall be filed with the board for
38 informational purposes before such rider may be sold.

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

47 (2) The benefit riders provided for in paragraph (1) of this
48 subsection shall be subject to the provisions of section 2, subsection

1 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
2 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
3 24, 17B:27A-25, and 17B:27A-27).

4 j. (1) Notwithstanding the provisions of P.L.1992, c.162
5 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
6 by or through a carrier, association, or multiple employer
7 arrangement prior to January 1, 1994 or, if the requirements of
8 subparagraph (c) of paragraph (6) of this subsection are met, issued
9 by or through an out-of-State trust prior to January 1, 1994, at the
10 option of a small employer policy or contract holder, may be
11 renewed or continued after February 28, 1994, or in the case of such
12 a health benefits plan whose anniversary date occurred between
13 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
14 19.1 et al.), may be reinstated within 60 days of that anniversary
15 date and renewed or continued if, beginning on the first 12-month
16 anniversary date occurring on or after the sixtieth day after the
17 board adopts regulations concerning the implementation of the
18 rating factors permitted by section 9 of P.L.1992, c.162
19 (C.17B:27A-25) and, regardless of the situs of delivery of the health
20 benefits plan, the health benefits plan renewed, continued or
21 reinstated pursuant to this subsection complies with the provisions
22 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
23 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
24 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
25 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

26 Nothing in this subsection shall be construed to require an
27 association, multiple employer arrangement or out-of-State trust to
28 provide health benefits coverage to small employers that are not
29 contemplated by the organizational documents, bylaws, or other
30 regulations governing the purpose and operation of the association,
31 multiple employer arrangement or out-of-State trust.
32 Notwithstanding the foregoing provision to the contrary, an
33 association, multiple employer arrangement or out-of-State trust
34 that offers health benefits coverage to its members' employees and
35 dependents:

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

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

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

45 (2) Notwithstanding the provisions of this subsection to the
46 contrary, a carrier or out-of-State trust which writes the health
47 benefits plans required pursuant to subsection a. of this section shall

1 be required to offer those plans to any small employer, association
2 or multiple employer arrangement.

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

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

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

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

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

37 (b) A health benefits plan filed with the commissioner pursuant
38 to subparagraph (a) of this paragraph may be amended as to its
39 benefit structure if the amendment does not reduce the actuarial
40 value and benefits coverage of the health benefits plan below that of
41 the lowest standard health benefits plan established by the board
42 pursuant to subsection a. of this section. The amendment shall be
43 filed with the commissioner for approval pursuant to the terms of
44 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
45 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
46 applicable, and shall comply with the provisions of sections 2 and 9
47 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
48 of P.L.1995, c.340 (C.17B:27A-19.3).

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

15 (7) Notwithstanding the provisions of P.L.1992, c.162
16 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
17 employer arrangement or out-of-State trust may offer a health
18 benefits plan authorized to be renewed, continued or reinstated
19 pursuant to this subsection to small employer groups that are
20 otherwise eligible pursuant to paragraph (1) of subsection j. of this
21 section during the period for which such health benefits plan is
22 otherwise authorized to be renewed, continued or reinstated.

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

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

44 (10) In a case in which an association made available a health
45 benefits plan on or before March 1, 1994 and subsequently changed
46 the issuing carrier between March 1, 1994 and the effective date of
47 P.L.1995, c.340, the new issuing carrier shall be deemed to have

1 been eligible to continue and renew the plan pursuant to paragraph
2 (1) of this subsection.

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

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

18 Notwithstanding the provisions of subparagraph (b) of paragraph
19 (6) of this subsection to the contrary, a small employer who changes
20 its health benefits plan's issuing carrier pursuant to the provisions of
21 this paragraph, shall not, upon changing carriers, modify the benefit
22 structure of that health benefits plan within six months of the date
23 the issuing carrier was changed.

24 k. Effective immediately for a health benefits plan issued on or
25 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
26 and effective on the first 12-month anniversary date of a health
27 benefits plan in effect on the effective date of P.L.2005, c.248
28 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
29 to this section, including any plans offered by a State approved or
30 federally qualified health maintenance organization, shall contain
31 benefits for expenses incurred in the following:

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

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

47 (3) Screening for newborn hearing loss by appropriate
48 electrophysiologic screening measures and periodic monitoring of

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

6 The benefits provided pursuant to this subsection shall be
7 provided to the same extent as for any other medical condition
8 under the health benefits plan, except that a deductible shall not be
9 applied for benefits provided pursuant to this subsection; however,
10 with respect to a small employer health benefits plan that qualifies
11 as a high deductible health plan for which qualified medical
12 expenses are paid using a health savings account established
13 pursuant to section 223 of the federal Internal Revenue Code of
14 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
15 benefits that represent preventive care as permitted by that federal
16 law, and shall not be applied as provided pursuant to section 16 of
17 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
18 all small employer health benefits plans in which the carrier has
19 reserved the right to change the premium.

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

25 m. Effective immediately for a health benefits plan issued on or
26 after the effective date of **[P.L.2001, c.361 (C.17:48-6z et al.)]**
27 **P.L. , c. (C.)(pending before the Legislature as this bill)** and
28 effective on the first 12-month anniversary date of a health benefits
29 plan in effect on the effective date of **[P.L.2001, c.361 (C.17:48-6z**
30 **et al.)]** **P.L. , c. (C.)(pending before the Legislature as this bill)**,
31 the health benefits plans required pursuant to this section **[that**
32 **provide benefits for expenses incurred in the purchase of**
33 **prescription drugs]** shall provide benefits for expenses incurred in
34 the purchase of specialized non-standard infant formulas, when the
35 covered infant's physician has diagnosed the infant as having
36 multiple food protein intolerance and has determined such formula
37 to be medically necessary, and when the covered infant has not been
38 responsive to trials of standard non-cow milk-based formulas,
39 including soybean and goat milk. The coverage may be subject to
40 utilization review, including periodic review, of the continued
41 medical necessity of the specialized infant formula.

42 The benefits shall be provided to the same extent as for any other
43 **[prescribed items]** conditions under the health benefits plan.

44 This subsection shall apply to all small employer health benefits
45 plans in which the carrier has reserved the right to change the
46 premium.

1 n. Effective immediately for a health benefits plan issued on or
2 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
3 and effective on the first 12-month anniversary date of a small
4 employer health benefits plan in effect on the effective date of
5 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
6 required pursuant to this section that qualify as high deductible
7 health plans for which qualified medical expenses are paid using a
8 health savings account established pursuant to section 223 of the
9 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
10 any plans offered by a State approved or federally qualified health
11 maintenance organization, shall contain benefits for expenses
12 incurred in connection with any medically necessary benefits
13 provided in-network that represent preventive care as permitted by
14 that federal law.

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

21 m. Effective immediately for a health benefits plan issued on or
22 after the effective date of **[P.L.2001, c.361 (C.17:48-6z et al.)]**
23 P.L. , c. (C.)(pending before the Legislature as this bill) and
24 effective on the first 12-month anniversary date of a health benefits
25 plan in effect on the effective date of **[P.L.2001, c.361 (C.17:48-6z**
26 **et al.)]** P.L. , c. (C.)(pending before the Legislature as this
27 bill), the health benefits plans required pursuant to this section **[that**
28 **provide benefits for expenses incurred in the purchase of**
29 **prescription drugs]** shall provide benefits for expenses incurred in
30 the purchase of specialized non-standard infant formulas, when the
31 covered infant's physician has diagnosed the infant as having
32 multiple food protein intolerance and has determined such formula
33 to be medically necessary, and when the covered infant has not been
34 responsive to trials of standard non-cow milk-based formulas,
35 including soybean and goat milk. The coverage may be subject to
36 utilization review, including periodic review, of the continued
37 medical necessity of the specialized infant formula.

38 The benefits shall be provided to the same extent as for any other
39 **[prescribed items]** conditions under the health benefits plan.

40 This subsection shall apply to all small employer health benefits
41 plans in which the carrier has reserved the right to change the
42 premium.

43 (cf: P.L.2005, c.248, s.15)

44

45 9. This act shall take effect on the 60th day after enactment and
46 shall apply to all policies and contracts delivered, issued executed or
47 renewed in this State on or after the effective date.

STATEMENT

1

2

3 This bill amends P.L.2001, c.361 to clarify that all hospital,
4 medical and health service corporations, individual, small employer
5 and larger group insurers and health maintenance organizations
6 shall provide coverage for expenses incurred in the purchase of
7 specialized non-standard infant formulas, when the covered infant's
8 physician has diagnosed the infant as having multiple food protein
9 intolerance and has determined such formula to be medically
10 necessary, and when the covered infant has not been responsive to
11 trials of standard non-cow milk-based formulas, including soybean
12 and goat milk.

13 As originally enacted, P.L.2001, c.361 specified that insurers
14 that provide coverage for prescription drugs shall provide the
15 coverage for the infant formulas. This requirement has resulted in
16 inequitable treatment of insured persons whose health benefits
17 plans, which are subject to this law, do not include coverage for
18 prescription drugs. Further, since some of the infant formulas
19 covered under the law, such as Neocate, are not classified as
20 prescription drugs, although they are administered under a
21 physician's supervision, the insurance coverage for the infant
22 formulas should not be limited to plans that only provide
23 prescription drug coverage.