17:48-6z

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 361

NJSA: 17:48-6z (Insurance coverage for certain infant formulas)

BILL NO: S1839 (Substituted for A3976)

SPONSOR(S): Robertson and Allen

DATE INTRODUCED: November 9, 2000

COMMITTEE: **ASSEMBLY:** Banking and Insurance

SENATE: Health

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** January 3, 2002

SENATE: March 26, 2001

DATE OF APPROVAL: January 6, 2002

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (1st reprint enacted)

(Amendments during passage denoted by superscript numbers)

S1839

SPONSORS STATEMENT: (Begins on page 13 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

A3976

SPONSORS STATEMENT: (Begins on page 14 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

Identical to Assembly Committee Statement for S1839

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

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SENATE, No. 1839

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED NOVEMBER 9, 2000

Sponsored by:
Senator NORMAN M. ROBERTSON
District 34 (Essex and Passaic)

SYNOPSIS
Mandates health insurance coverage for certain infant formulas.

CURRENT VERSION OF TEXT
As introduced.

1 **AN ACT** concerning coverage of certain infant formulas,
2 supplementing Titles 17 and 26 of the Revised Statutes and Title
3 17B of the New Jersey Statutes, and amending P.L.1992, c.161 and
4 P.L.1992, c.162.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) A hospital service corporation which provides
10 hospital or medical expense benefits under a contract that is delivered,
11 issued, executed or renewed in this State, or approved for issuance or
12 renewal in this State by the Commissioner of Banking and Insurance
13 on or after the effective date of this act, shall provide benefits under
14 the contract for expenses incurred in the purchase of specialized infant
15 formulas, when the covered infant's physician has diagnosed the infant
16 as having cow milk allergy and multiple food protein intolerance and
17 has determined such formula to be medically necessary.
18 The benefits shall be provided to the same extent as for any other
19 medical condition under the contract.
20 This section shall apply to those hospital service corporation
21 contracts in which the hospital service corporation has reserved the
22 right to change the premium.
23
24 2. (New section) A medical service corporation which provides
25 hospital or medical expense benefits under a contract that is delivered,
26 issued, executed or renewed in this State, or approved for issuance or
27 renewal in this State by the Commissioner of Banking and Insurance
28 on or after the effective date of this act, shall provide benefits under
29 the contract for expenses incurred in the purchase of specialized infant
30 formulas, when the covered infant's physician has diagnosed the infant
31 as having cow milk allergy and multiple food protein intolerance and
32 has determined such formula to be medically necessary.
33 The benefits shall be provided to the same extent as for any other
34 medical condition under the contract.
35 This section shall apply to those medical service corporation
36 contracts in which the medical service corporation has reserved the
37 right to change the premium.
38
39 3. (New section) A health service corporation which provides
40 hospital or medical expense benefits under a contract that is delivered,
41 issued, executed or renewed in this State, or approved for issuance or
42 renewal in this State by the Commissioner of Banking and Insurance
43 on or after the effective date of this act, shall provide benefits under

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.

the contract for expenses incurred in the purchase of specialized infant formulas, when the covered infant's physician has diagnosed the infant as having cow milk allergy and multiple food protein intolerance and has determined such formula to be medically necessary.

The benefits shall be provided to the same extent as for any other medical condition 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 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 infant formulas, when the covered infant's physician has diagnosed the infant as having cow milk allergy and multiple food protein intolerance and has determined such formula to be medically necessary.

The benefits shall be provided to the same extent as for any other medical condition 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 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 infant formulas, when the covered infant's physician has diagnosed the infant as having cow milk allergy and multiple food protein intolerance and has determined such formula to be medically necessary.

The benefits shall be provided to the same extent as for any other medical condition 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, unless the health maintenance organization also provides health care services in the purchase of specialized infant formulas, when the covered infant's physician has diagnosed the infant as having cow milk allergy and multiple food protein intolerance and has determined such formula to be medically

1 necessary.
2 The health care services shall be provided to the same extent as for
3 any other medical condition under the contract.
4 The provisions of this section shall apply to those contracts for
5 health care services by health maintenance organizations under which
6 the health maintenance organization has reserved the right to change
7 the schedule of charges for enrollee coverage.
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 benefits
13 plans required to be issued pursuant to section 3 of P.L.1992, c.161
14 (C.17B:27A-4), and shall adopt such modifications to one or more
15 plans as the board determines are necessary to make available a "high
16 deductible health plan" or plans consistent with section 301 of Title III
17 of the "Health Insurance Portability and Accountability Act of 1996,"
18 Pub.L.104-191, regarding tax-deductible medical savings accounts,
19 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
20 al.). The board shall provide the commissioner with an informational
21 filing of the policy and contract forms and benefit levels it establishes.
22 a. The individual health benefits plans established by the board
23 may include cost containment measures such as, but not limited to:
24 utilization review of health care services, including review of medical
25 necessity of hospital and physician services; case management benefit
26 alternatives; selective contracting with hospitals, physicians, and other
27 health care providers; and reasonable benefit differentials applicable to
28 participating and nonparticipating providers; and other managed care
29 provisions.
30 b. An individual health benefits plan offered pursuant to section
31 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
32 more than 12 months on coverage for preexisting conditions. An
33 individual health benefits plan offered pursuant to section 3 of
34 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
35 condition limitation of any period under the following circumstances:
36 (1) to an individual who has, under creditable coverage, with no
37 intervening lapse in coverage of more than 31 days, been treated or
38 diagnosed by a physician for a condition under that plan or satisfied a
39 12-month preexisting condition limitation; or
40 (2) to a federally defined eligible individual who applies for an
41 individual health benefits plan within 63 days of termination of the
42 prior coverage.
43 c. In addition to the five standard individual health benefits plans
44 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
45 may develop up to five rider packages. Premium rates for the rider
46 packages shall be determined in accordance with section 8 of

1 P.L.1992, c.161 (C.17B:27A-9).
2 d. After the board's establishment of the individual health benefits
3 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 carrier
5 shall file the policy or contract forms with the board and certify to the
6 board that the health benefits plans to be used by the carrier are in
7 substantial compliance with the provisions in the corresponding board
8 approved plans. The certification shall be signed by the chief
9 executive officer of the carrier. Upon receipt by the board of the
10 certification, the certified plans may be used until the board, after
11 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
14 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
15 date of an individual health benefits plan in effect on the effective date
16 of 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 the
23 Department of Health and Senior Services pursuant to section 7 of
24 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 children.
26 (2) All childhood immunizations as recommended by the Advisory
27 Committee on Immunization Practices of the United States Public
28 Health Service and the Department of Health and Senior Services
29 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
30 shall notify its insureds, in writing, of any change in the health care
31 services provided with respect to childhood immunizations and any
32 related changes in premium. Such notification shall be in a form and
33 manner to be determined by the Commissioner of Banking and
34 Insurance.
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 [section] <u>subsection</u>. This [section] <u>subsection</u> shall apply to all
39 individual health benefits plans in which the carrier has reserved the
40 right to change the premium.
41 <u>f. Effective immediately for a health benefits plan issued on or after</u>
42 <u>the effective date of P.L. , c. (C.)(pending before the Legislature as</u>
43 <u>this bill) and effective on the first 12-month anniversary date of a</u>
44 <u>health benefits plan in effect on the effective date of P.L. , c. (C.)</u>
45 <u>(pending before the Legislature as this bill), the health benefits plans</u>
46 <u>required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall</u>

1 provide benefits for expenses incurred in the purchase of specialized
2 infant formulas, when the covered infant's physician has diagnosed the
3 infant as having cow milk allergy and multiple food protein intolerance
4 and has determined such formula to be medically necessary.
5 The benefits shall be provided to the same extent as for any other
6 medical condition under the health benefits plan.
7 This subsection shall apply to all individual health benefits plans in
8 which the carrier has reserved the right to change the premium.
9 (cf: P.L.1997, c.414, s.1)
10
11 8. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
12 read as follows:
13 3. a. Except as provided in subsection f. of this section, every
14 small employer carrier shall, as a condition of transacting business in
15 this State, offer to every small employer the five health benefit plans
16 as provided in this section. The board shall establish a standard policy
17 form for each of the five plans, which except as otherwise provided in
18 subsection j. of this section, shall be the only plans offered to small
19 groups on or after January 1, 1994. One policy form shall contain the
20 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
21 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
22 carriers, one policy form shall be established which contains benefits
23 and cost sharing levels which are equivalent to the health benefits
24 plans of health maintenance organizations pursuant to the "Health
25 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
26 s.300e et seq.). The remaining policy forms shall contain basic hospital
27 and medical-surgical benefits, including, but not limited to:
28 (1) Basic inpatient and outpatient hospital care;
29 (2) Basic and extended medical-surgical benefits;
30 (3) Diagnostic tests, including X-rays;
31 (4) Maternity benefits, including prenatal and postnatal care; and
32 (5) Preventive medicine, including periodic physical examinations
33 and inoculations.
34 At least three of the forms shall provide for major medical benefits
35 in varying lifetime aggregates, one of which shall provide at least
36 $1,000,000 in lifetime aggregate benefits. The policy forms provided
37 pursuant to this section shall contain benefits representing
38 progressively greater actuarial values.
39 Notwithstanding the provisions of this subsection to the contrary,
40 the board also may establish additional policy forms by which a small
41 employer carrier, other than a health maintenance organization, may
42 provide indemnity benefits for health maintenance organization
43 enrollees by direct contract with the enrollees' small employer through
44 a dual arrangement with the health maintenance organization. The
45 dual arrangement shall be filed with the commissioner for approval.
46 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 ensure 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 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e 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.

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.

1 g. A carrier shall not be required to own or control a health
2 maintenance organization or otherwise affiliate with a health
3 maintenance organization in order to comply with the provisions of
4 this section, but the carrier shall be required to offer the five health
5 benefits plans which are formulated by the board and approved by the
6 commissioner, including one plan which contains benefits and cost
7 sharing levels that are equivalent to those required for health
8 maintenance organizations.
9 h. Notwithstanding the provisions of subsection a. of this section
10 to the contrary, the board may modify the benefits provided for in
11 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2
12 and 26:2J-4.3).
13 i. (1) In addition to the rider packages provided for in subsection d.
14 of this section, every carrier may offer, in connection with the five
15 health benefits plans required to be offered by this section, any number
16 of riders which may revise the coverage offered by the five plans in
17 any way, provided, however, that any form of such rider or
18 amendment thereof which decreases benefits or decreases the actuarial
19 value of one of the five plans shall be filed for informational purposes
20 with the board and for approval by the commissioner before such rider
21 may be sold. Any rider or amendment thereof which adds benefits or
22 increases the actuarial value of one of the five plans shall be filed with
23 the board for informational purposes before such rider may be sold.
24 The commissioner shall disapprove any rider filed pursuant to this
25 subsection that is unjust, unfair, inequitable, unreasonably
26 discriminatory, misleading, contrary to law or the public policy of this
27 State. The commissioner shall not approve any rider which reduces
28 benefits below those required by sections 55, 57 and 59 of P.L.1991,
29 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be
30 sold pursuant to this section. The commissioner's determination shall
31 be in writing and shall be appealable.
32 (2) The benefit riders provided for in paragraph (1) of this
33 subsection shall be subject to the provisions of section 2, subsection
34 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
35 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23,
36 17B:27A-24, 17B:27A-25, and 17B:27A-27).
37 j. (1) Notwithstanding the provisions of P.L.1992, c.162
38 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
39 by or through a carrier, association, multiple employer arrangement
40 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
41 paragraph (6) of this subsection are met, issued by or through an
42 out-of-State trust prior to January 1, 1994, at the option of a small
43 employer policy or contract holder, may be renewed or continued after
44 February 28, 1994, or in the case of such a health benefits plan whose
45 anniversary date occurred between March 1, 1994 and the effective
46 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated

1 within 60 days of that anniversary date and renewed or continued if,
2 beginning on the first 12-month anniversary date occurring on or after
3 the sixtieth day after the board adopts regulations concerning the
4 implementation of the rating factors permitted by section 9 of
5 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
6 delivery of the health benefits plan, the health benefits plan renewed,
7 continued or reinstated pursuant to this subsection complies with the
8 provisions of section 2, subsection b. of section 3, and sections 6, 7,
9 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
10 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
11 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).
12 Nothing in this subsection shall be construed to require an
13 association, multiple employer arrangement or out-of-State trust to
14 provide health benefits coverage to small employers that are not
15 contemplated by the organizational documents, bylaws, or other
16 regulations governing the purpose and operation of the association,
17 multiple employer arrangement or out-of-State trust. Notwithstanding
18 the foregoing provision to the contrary, an association, multiple
19 employer arrangement or out-of-State trust that offers health benefits
20 coverage to its members' employees and dependents:
21 (a) shall offer coverage to all eligible employees and their
22 dependents within the membership of the association, multiple
23 employer arrangement or out-of-State trust;
24 (b) shall not use actual or expected health status in determining its
25 membership; and
26 (c) shall make available to its small employer members at least one
27 of the standard benefits plans, as determined by the commissioner, in
28 addition to any health benefits plan permitted to be renewed or
29 continued pursuant to this subsection.
30 (2) Notwithstanding the provisions of this subsection to the
31 contrary, a carrier or out-of-State trust which writes the health
32 benefits plans required pursuant to subsection a. of this section shall
33 be required to offer those plans to any small employer, association or
34 multiple employer arrangement.
35 (3) (a) A carrier, association, multiple employer arrangement or
36 out-of-State trust may withdraw a health benefits plan marketed to
37 small employers that was in effect on December 31, 1993 with the
38 approval of the commissioner. The commissioner shall approve a
39 request to withdraw a plan, consistent with regulations adopted by the
40 commissioner, only on the grounds that retention of the plan would
41 cause an unreasonable financial **[**burder**]** burden to the issuing carrier,
42 taking into account the rating provisions of section 9 of P.L.1992,
43 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
44 (C.17B:27A-19.3).
45 (b) A carrier which has renewed, continued or reinstated a health
46 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.

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

(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

1 renewed after the 180-day period.
2 (7) Notwithstanding the provisions of P.L.1992, c.162
3 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
4 employer arrangement or out-of-State trust may offer a health benefits
5 plan authorized to be renewed, continued or reinstated pursuant to this
6 subsection to small employer groups that are otherwise eligible
7 pursuant to paragraph (1) of subsection j. of this section during the
8 period for which such health benefits plan is otherwise authorized to
9 be renewed, continued or reinstated.
10 (8) Notwithstanding the provisions of P.L.1992, c.162
11 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
12 employer arrangement or out-of-State trust may offer coverage under
13 a health benefits plan authorized to be renewed, continued or
14 reinstated pursuant to this subsection to new employees of small
15 employer groups covered by the health benefits plan in accordance
16 with the provisions of paragraph (1) of this subsection.
17 (9) Notwithstanding the provisions of P.L.1992, c.162
18 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
19 the contrary, any individual, who is eligible for small employer
20 coverage under a policy issued, renewed, continued or reinstated
21 pursuant to this subsection, but who would be subject to a preexisting
22 condition exclusion under the small employer health benefits plan, or
23 who is a member of a small employer group who has been denied
24 coverage under the small employer group health benefits plan for
25 health reasons, may elect to purchase or continue coverage under an
26 individual health benefits plan until such time as the group health
27 benefits plan covering the small employer group of which the
28 individual is a member complies with the provisions of P.L.1992, c.162
29 (C.17B:27A-17 et seq.).
30 (10) In a case in which an association made available a health
31 benefits plan on or before March 1, 1994 and subsequently changed
32 the issuing carrier between March 1, 1994 and the effective date of
33 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
34 eligible to continue and renew the plan pursuant to paragraph (1) of
35 this subsection.
36 (11) In a case in which an association, multiple employer
37 arrangement or out-of-State trust made available a health benefits plan
38 on or before March 1, 1994 and subsequently changes the issuing
39 carrier for that plan after the effective date of P.L.1995, c.340, the
40 new issuing carrier shall file the health benefits plan with the
41 commissioner for approval in order to be deemed eligible to continue
42 and renew that plan pursuant to paragraph (1) of this subsection.
43 (12) In a case in which a small employer purchased a health benefits
44 plan directly from a carrier on or before March 1, 1994 and
45 subsequently changes the issuing carrier for that plan after the
46 effective date of P.L.1995, c.340, the new issuing carrier shall file the

1 health benefits plan with the commissioner for approval in order to be
2 deemed eligible to continue and renew that plan pursuant to paragraph
3 (1) of this subsection.
4 Notwithstanding the provisions of subparagraph (b) of paragraph
5 (6) of this subsection to the contrary, a small employer who changes
6 its health benefits plan's issuing carrier pursuant to the provisions of
7 this paragraph, shall not, upon changing carriers, modify the benefit
8 structure of that health benefits plan within six months of the date the
9 issuing carrier was changed.
10 k. Effective immediately for a health benefits plan issued on or
11 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and
12 effective on the first 12-month anniversary date of a health benefits
13 plan in effect on the effective date of P.L.1995, c.316
14 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to
15 this section, including any plans offered by a State approved or
16 federally qualified health maintenance organization, shall contain
17 benefits for expenses incurred in the following:
18 (1) Screening by blood lead measurement for lead poisoning for
19 children, including confirmatory blood lead testing as specified by the
20 Department of Health and Senior Services pursuant to section 7 of
21 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
22 necessary medical follow-up and treatment for lead poisoned children.
23 (2) All childhood immunization as recommended by the Advisory
24 Committee on Immunization Practices of the United State Public
25 Health Service and the Department of Health and Senior Services
26 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
27 shall notify its insureds, in writing, of any change in the health care
28 services provided with respect to childhood immunizations and any
29 related changes in premium. Such notification shall be in a form and
30 manner to be determined by the Commissioner of Banking and
31 Insurance.
32 The benefits shall be provided to the same extent as for any other
33 medical condition under the health benefits plan, except that no
34 deductible shall be applied for benefits provided pursuant to this
35 [section] <u>subsection</u>. This [section] <u>subsection</u> shall apply to all
36 small employer health benefits plans in which the carrier has reserved
37 the right to change the premium.
38 l. The board shall consider including benefits for speech-language
39 pathology and audiology services, as rendered by speech-language
40 pathologists and audiologists within the scope of their practices, in at
41 least one of the five standard policies and in at least one of the five
42 riders to be developed under this section.
43 <u>m. Effective immediately for a health benefits plan issued on or</u>
44 <u>after the effective date of P.L. , c. (C.)(pending before the</u>
45 <u>Legislature as this bill) and effective on the first 12-month anniversary</u>
46 <u>date of a health benefits plan in effect on the effective date of P.L. ,</u>

c. (C.)(pending before the Legislature as this bill), the health benefits plans required pursuant to this section shall provide benefits for expenses incurred in the purchase of specialized infant formulas, when the covered infant's physician has diagnosed the infant as having cow milk allergy and multiple food protein intolerance and has determined such formula to be medically necessary.

The benefits shall be provided to the same extent as for any other medical condition 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 immediately.

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 infant formulas. Infants who suffer from cow milk allergy and multiple food protein intolerance are unable to digest either cow's milk-based or soy-based formulas. As a result, their physicians determine specialty formulas to be medically necessary. 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.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 1839

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 22, 2001

The Senate Health Committee reports favorably and with committee amendments Senate Bill No. 1839.

As amended by the committee, 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.

The committee amended the bill to limit coverage for specialized infant formulas to plans that offer prescription drug benefits and to infants who have been diagnosed with multiple food protein tolerance and have not responded to trials of standard non-cow milk-based formulas, including soybean and goat milk. Committee amendments also allow coverage for specialized infant formulas to be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula. The committee amended the bill to change the effective date from immediately to 60 days following enactment of the bill.

[First Reprint]

SENATE, No. 1839

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED NOVEMBER 9, 2000

Sponsored by:
Senator NORMAN M. ROBERTSON
District 34 (Essex and Passaic)
Senator DIANE ALLEN
District 7 (Burlington and Camden)

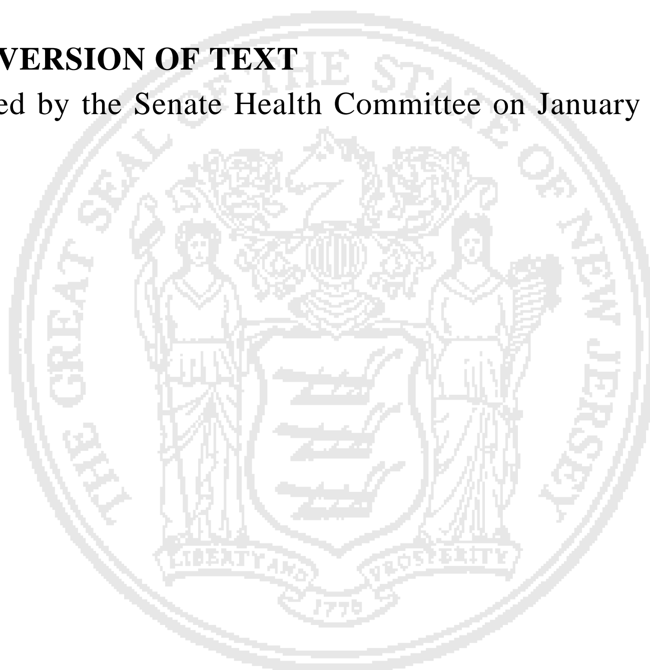
Co-Sponsored by:
Senators Singer, Sinagra, Matheussen, Bucco, Kosco, Assemblymen Pennacchio and Corodemus

SYNOPSIS

Mandates health insurance coverage for certain infant formulas.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee on January 22, 2001, with amendments.



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

AN ACT concerning coverage of certain infant formulas, supplementing Titles 17 and 26 of the Revised Statutes and Title 17B of the New Jersey Statutes, and amending P.L.1992, c.161 and P.L.1992, c.162.

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 [1]for expenses incurred in the purchase of prescription drugs[1] 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 [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1]**[**cow milk allergy and**]**[1] multiple food protein intolerance and has determined such formula to be medically necessary[1], 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[1].

The benefits shall be provided to the same extent as for any other [1]**[**medical condition**]** prescribed items[1] 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 [1]for expenses incurred in the purchase of prescription drugs[1] 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 [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1]**[**cow milk allergy and**]**[1] multiple food protein intolerance and has determined such formula to be medically necessary[1], and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted January 22, 2001.

1 goat milk. The coverage may be subject to utilization review,
2 including periodic review, of the continued medical necessity of the
3 specialized infant formula[1].
4 The benefits shall be provided to the same extent as for any other
5 [1][medical condition] prescribed items[1] under the contract.
6 This section shall apply to those medical service corporation
7 contracts in which the medical service corporation has reserved the
8 right to change the premium.
9
10 3. (New section) A health service corporation which provides
11 hospital or medical expense benefits [1]for expenses incurred in the
12 purchase of prescription drugs[1] under a contract that is delivered,
13 issued, executed or renewed in this State, or approved for issuance or
14 renewal in this State by the Commissioner of Banking and Insurance
15 on or after the effective date of this act, shall provide benefits under
16 the contract for expenses incurred in the purchase of specialized [1]non-
17 standard[1] infant formulas, when the covered infant's physician has
18 diagnosed the infant as having [1][cow milk allergy and][1] multiple food
19 protein intolerance and has determined such formula to be medically
20 necessary[1], and when the covered infant has not been responsive to
21 trials of standard non-cow milk-based formulas, including soybean and
22 goat milk. The coverage may be subject to utilization review,
23 including periodic review, of the continued medical necessity of the
24 specialized infant formula[1].
25 The benefits shall be provided to the same extent as for any other
26 [1][medical condition] prescribed items[1] under the contract.
27 This section shall apply to those health service corporation
28 contracts in which the health service corporation has reserved the right
29 to change the premium.
30
31 4. (New section) A group health insurer which provides hospital
32 or medical expense benefits [1]for expenses incurred in the purchase of
33 prescription drugs[1] under a policy that is delivered, issued, executed
34 or renewed in this State, or approved for issuance or renewal in this
35 State by the Commissioner of Banking and Insurance on or after the
36 effective date of this act, shall provide benefits under the policy for
37 expenses incurred in the purchase of specialized [1]non-standard[1] infant
38 formulas, when the covered infant's physician has diagnosed the infant
39 as having [1][cow milk allergy and][1] multiple food protein intolerance
40 and has determined such formula to be medically necessary[1], and when
41 the covered infant has not been responsive to trials of standard non-
42 cow milk-based formulas, including soybean and goat milk. The
43 coverage may be subject to utilization review, including periodic
44 review, of the continued medical necessity of the specialized infant
45 formula[1].
46 The benefits shall be provided to the same extent as for any other

1 [1][medical condition] prescribed items[1] under the policy.
2 This section shall apply to those policies in which the insurer has
3 reserved the right to change the premium.
4
5 5. (New section) An individual health insurer which provides
6 hospital or medical expense benefits [1]for expenses incurred in the
7 purchase of prescription drugs[1] under a policy that is delivered, issued,
8 executed or renewed in this State, or approved for issuance or renewal
9 in this State by the Commissioner of Banking and Insurance on or after
10 the effective date of this act, shall provide benefits under the policy for
11 expenses incurred in the purchase of specialized [1]non-standard[1] infant
12 formulas, when the covered infant's physician has diagnosed the infant
13 as having [1][cow milk allergy and][1] multiple food protein intolerance
14 and has determined such formula to be medically necessary[1], and when
15 the covered infant has not been responsive to trials of standard non-
16 cow milk-based formulas, including soybean and goat milk. The
17 coverage may be subject to utilization review, including periodic
18 review, of the continued medical necessity of the specialized infant
19 formula[1].
20 The benefits shall be provided to the same extent as for any other
21 [1][medical condition] prescribed items[1] under the policy.
22 This section shall apply to those policies in which the insurer has
23 reserved the right to change the premium.
24
25 6. (New section) A certificate of authority to establish and
26 operate a health maintenance organization in this State shall not be
27 issued or continued on or after the effective date of this act for a
28 health maintenance organization [1]that provides health care services for
29 prescription drugs under a contract[1], unless the health maintenance
30 organization also provides health care services in the purchase of
31 specialized [1]non-standard[1] infant formulas, when the covered infant's
32 physician has diagnosed the infant as having [1][cow milk allergy and][1]
33 multiple food protein intolerance and has determined such formula to
34 be medically necessary[1], and when the covered infant has not been
35 responsive to trials of standard non-cow milk-based formulas,
36 including soybean and goat milk. The coverage may be subject to
37 utilization review, including periodic review, of the continued medical
38 necessity of the specialized infant formula[1].
39 The health care services shall be provided to the same extent as for
40 any other [1][medical condition] prescribed items[1] under the contract.
41 The provisions of this section shall apply to those contracts for
42 health care services by health maintenance organizations under which
43 the health maintenance organization has reserved the right to change
44 the schedule of charges for enrollee coverage.
45
46 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

1 certification, the certified plans may be used until the board, after
2 notice and hearing, disapproves their continued use.
3 e. Effective immediately for an individual health benefits plan
4 issued on or after the effective date of P.L.1995, c.316
5 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
6 date of an individual health benefits plan in effect on the effective date
7 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
8 benefits plans required pursuant to section 3 of P.L.1992, c.161
9 (C.17B:27A-4), including any plan offered by a federally qualified
10 health maintenance organization, shall contain benefits for expenses
11 incurred in the following:
12 (1) Screening by blood lead measurement for lead poisoning for
13 children, including confirmatory blood lead testing as specified by the
14 Department of Health and Senior Services pursuant to section 7 of
15 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
16 necessary medical follow-up and treatment for lead poisoned children.
17 (2) All childhood immunizations as recommended by the Advisory
18 Committee on Immunization Practices of the United States Public
19 Health Service and the Department of Health and Senior Services
20 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
21 shall notify its insureds, in writing, of any change in the health care
22 services provided with respect to childhood immunizations and any
23 related changes in premium. Such notification shall be in a form and
24 manner to be determined by the Commissioner of Banking and
25 Insurance.
26 The benefits shall be provided to the same extent as for any other
27 medical condition under the health benefits plan, except that no
28 deductible shall be applied for benefits provided pursuant to this
29 [section] subsection. This [section] subsection shall apply to all
30 individual health benefits plans in which the carrier has reserved the
31 right to change the premium.
32 f. Effective immediately for a health benefits plan issued on or after
33 the effective date of P.L. , c. (C.)(pending before the Legislature as
34 this bill) and effective on the first 12-month anniversary date of a
35 health benefits plan in effect on the effective date of P.L. , c. (C.)
36 (pending before the Legislature as this bill), the health benefits plans
37 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) [1]that
38 provide benefits for expenses incurred in the purchase of prescription
39 drugs[1] shall provide benefits for expenses incurred in the purchase of
40 specialized [1]non-standard[1] infant formulas, when the covered infant's
41 physician has diagnosed the infant as having [1][cow milk allergy and][1]
42 multiple food protein intolerance and has determined such formula to
43 be medically necessary[1], 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[1].
2 The benefits shall be provided to the same extent as for any other
3 [1][medical condition] prescribed items[1] 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.1997, c.414, s.1)
7
8 8. 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 d.
11 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-19b., 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, 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-19b.,
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 [burder] <u>burden</u> to the issuing carrier,
39 taking into account the rating provisions of section 9 of P.L.1992,
40 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
41 (C.17B:27A-19.3).
42 (b) A carrier which has renewed, continued or reinstated a health
43 benefits plan pursuant to this subsection that has not been newly issued
44 to a new small employer group since January 1, 1994, may, upon
45 approval of the commissioner, continue to establish its rates for that
46 plan based on the loss experience of that plan if the carrier does not

1 issue that health benefits plan to any new small employer groups.
2 (4) (Deleted by amendment, P.L.1995, c.340).
3 (5) A health benefits plan that otherwise conforms to the
4 requirements of this subsection shall be deemed to be in compliance
5 with this subsection, notwithstanding any change in the plan's
6 deductible or copayment.
7 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
8 of this paragraph, a health benefits plan renewed, continued or
9 reinstated pursuant to this subsection shall be filed with the
10 commissioner for informational purposes within 30 days after its
11 renewal date. No later than 60 days after the board adopts regulations
12 concerning the implementation of the rating factors permitted by
13 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
14 amended to show any modifications in the plan that are necessary to
15 comply with the provisions of this subsection. The commissioner shall
16 monitor compliance of any such plan with the requirements of this
17 subsection, except that the board shall enforce the loss ratio
18 requirements.
19 (b) A health benefits plan filed with the commissioner pursuant to
20 subparagraph (a) of this paragraph may be amended as to its benefit
21 structure if the amendment does not reduce the actuarial value and
22 benefits coverage of the health benefits plan below that of the lowest
23 standard health benefits plan established by the board pursuant to
24 subsection a. of this section. The amendment shall be filed with the
25 commissioner for approval pursuant to the terms of sections 4, 8, 12
26 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
27 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
28 shall comply with the provisions of sections 2 and 9 of P.L.1992,
29 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
30 c.340 (C.17B:27A-19.3).
31 (c) A health benefits plan issued by a carrier through an
32 out-of-State trust shall be permitted to be renewed or continued
33 pursuant to paragraph (1) of this subsection upon approval by the
34 commissioner and only if the benefits offered under the plan are at
35 least equal to the actuarial value and benefits coverage of the lowest
36 standard health benefits plan established by the board pursuant to
37 subsection a. of this section. For the purposes of meeting the
38 requirements of this subparagraph, carriers shall be required to file
39 with the commissioner the health benefits plans issued through an
40 out-of-State trust no later than 180 days after the date of enactment
41 of P.L.1995, c.340. A health benefits plan issued by a carrier through
42 an out-of-State trust that is not filed with the commissioner pursuant
43 to this subparagraph, shall not be permitted to be continued or
44 renewed after the 180-day period.
45 (7) Notwithstanding the provisions of P.L.1992, c.162
46 (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 State 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] <u>subsection</u>. This [section] <u>subsection</u> 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.

<u>m. Effective immediately for a health benefits plan issued on or after the effective date of P.L. , c. (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. (C.)(pending before the Legislature as this bill), the health benefits plans required pursuant to this section</u> [1]<u>that provide benefits for expenses incurred in the purchase of prescription drugs</u>[1] <u>shall</u>

1 provide benefits for expenses incurred in the purchase of specialized
2 [1]non-standard[1] infant formulas, when the covered infant's physician
3 has diagnosed the infant as having [1]**[**cow milk allergy and**]**[1] multiple
4 food protein intolerance and has determined such formula to be
5 medically necessary[1], and when the covered infant has not been
6 responsive to trials of standard non-cow milk-based formulas,
7 including soybean and goat milk. The coverage may be subject to
8 utilization review, including periodic review, of the continued medical
9 necessity of the specialized infant formula[1].
10 The benefits shall be provided to the same extent as for any other
11 [1]**[**medical condition**]** prescribed items[1] under the health benefits plan.
12 This subsection shall apply to all small employer health benefits
13 plans in which the carrier has reserved the right to change the
14 premium.
15 (cf: P.L.1997, c.419, s.6)
16
17 9. This act shall take effect [1]**[**immediately**]** on the 60th day
18 following enactment[1].

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 1839

STATE OF NEW JERSEY

DATED: DECEMBER 13, 2001

The Assembly Banking and Insurance Committee reports favorably Senate Bill No. 1839 (1R).

This bill requires health insurance carriers, including hospital, medical and health service corporations, commercial individual and group health insurers, health maintenance organizations and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs that offer prescription drug benefits, to provide benefits for expenses incurred in the purchase of certain infant formulas.

The bill specifies that benefits shall be provided for 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 bill also provides that the coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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)

1 **AN ACT** concerning coverage of certain infant formulas,
2 supplementing Titles 17 and 26 of the Revised Statutes and Title
3 17B of the New Jersey Statutes, and amending P.L.1992, c.161 and
4 P.L.1992, c.162.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) A hospital service corporation which provides
10 hospital or medical expense benefits for expenses incurred in the
11 purchase of prescription drugs under a contract that is delivered,
12 issued, executed or renewed in this State, or approved for issuance or
13 renewal in this State by the Commissioner of Banking and Insurance
14 on or after the effective date of this act, shall provide benefits under
15 the contract for expenses incurred in the purchase of specialized non-
16 standard infant formulas, when the covered infant's physician has
17 diagnosed the infant as having multiple food protein intolerance and
18 has determined such formula to be medically necessary, and when the
19 covered infant has not been responsive to trials of standard non-cow
20 milk-based formulas, including soybean and goat milk. The coverage
21 may be subject to utilization review, including periodic review, of the
22 continued medical necessity of the specialized infant formula.
23 The benefits shall be provided to the same extent as for any other
24 prescribed items under the contract.
25 This section shall apply to those hospital service corporation
26 contracts in which the hospital service corporation has reserved the
27 right to change the premium.
28
29 2. (New section) A medical service corporation which provides
30 hospital or medical expense benefits for expenses incurred in the
31 purchase of prescription drugs under a contract that is delivered,
32 issued, executed or renewed in this State, or approved for issuance or
33 renewal in this State by the Commissioner of Banking and Insurance
34 on or after the effective date of this act, shall provide benefits under
35 the contract for expenses incurred in the purchase of specialized non-
36 standard infant formulas, when the covered infant's physician has
37 diagnosed the infant as having multiple food protein intolerance and
38 has determined such formula to be medically necessary, and when the
39 covered infant has not been responsive to trials of standard non-cow
40 milk-based formulas, including soybean and goat milk. The coverage
41 may be subject to utilization review, including periodic review, of the
42 continued medical necessity of the specialized infant formula.
43 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.

1 prescribed items under the contract.
2 This section shall apply to those medical service corporation
3 contracts in which the medical service corporation has reserved the
4 right to change the premium.
5
6 3. (New section) A health service corporation which provides
7 hospital or medical expense benefits for expenses incurred in the
8 purchase of prescription drugs under a contract that is delivered,
9 issued, executed or renewed in this State, or approved for issuance or
10 renewal in this State by the Commissioner of Banking and Insurance
11 on or after the effective date of this act, shall provide benefits under
12 the contract for expenses incurred in the purchase of specialized non-
13 standard infant formulas, when the covered infant's physician has
14 diagnosed the infant as having multiple food protein intolerance and
15 has determined such formula to be medically necessary, and when the
16 covered infant has not been responsive to trials of standard non-cow
17 milk-based formulas, including soybean and goat milk. The coverage
18 may be subject to utilization review, including periodic review, of the
19 continued medical necessity of the specialized infant formula.
20 The benefits shall be provided to the same extent as for any other
21 prescribed items under the contract.
22 This section shall apply to those health service corporation
23 contracts in which the health service corporation has reserved the right
24 to change the premium.
25
26 4. (New section) A group health insurer which provides hospital
27 or medical expense benefits for expenses incurred in the purchase of
28 prescription drugs under a policy that is delivered, issued, executed or
29 renewed in this State, or approved for issuance or renewal in this State
30 by the Commissioner of Banking and Insurance on or after the
31 effective date of this act, shall provide benefits under the policy for
32 expenses incurred in the purchase of specialized non-standard infant
33 formulas, when the covered infant's physician has diagnosed the infant
34 as having multiple food protein intolerance and has determined such
35 formula to be medically necessary, and when the covered infant has
36 not been responsive to trials of standard non-cow milk-based formulas,
37 including soybean and goat milk. The coverage may be subject to
38 utilization review, including periodic review, of the continued medical
39 necessity of the specialized infant formula.
40 The benefits shall be provided to the same extent as for any other
41 prescribed items under the policy.
42 This section shall apply to those policies in which the insurer has
43 reserved the right to change the premium.
44
45 5. (New section) An individual health insurer which provides
46 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 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 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

1 of the "Health Insurance Portability and Accountability Act of 1996,"
2 Pub.L.104-191, regarding tax-deductible medical savings accounts,
3 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
4 al.). The board shall provide the commissioner with an informational
5 filing of the policy and contract forms and benefit levels it establishes.
6 a. The individual health benefits plans established by the board may
7 include cost containment measures such as, but not limited to:
8 utilization review of health care services, including review of medical
9 necessity of hospital and physician services; case management benefit
10 alternatives; selective contracting with hospitals, physicians, and other
11 health care providers; and reasonable benefit differentials applicable to
12 participating and nonparticipating providers; and other managed care
13 provisions.
14 b. An individual health benefits plan offered pursuant to section 3
15 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
16 more than 12 months on coverage for preexisting conditions. An
17 individual health benefits plan offered pursuant to section 3 of
18 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
19 condition limitation of any period under the following circumstances:
20 (1) to an individual who has, under creditable coverage, with no
21 intervening lapse in coverage of more than 31 days, been treated or
22 diagnosed by a physician for a condition under that plan or satisfied a
23 12-month preexisting condition limitation; or
24 (2) to a federally defined eligible individual who applies for an
25 individual health benefits plan within 63 days of termination of the
26 prior coverage.
27 c. In addition to the five standard individual health benefits plans
28 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
29 may develop up to five rider packages. Premium rates for the rider
30 packages shall be determined in accordance with section 8 of
31 P.L.1992, c.161 (C.17B:27A-9).
32 d. After the board's establishment of the individual health benefits
33 plans required pursuant to section 3 of P.L.1992, c.161
34 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier
35 shall file the policy or contract forms with the board and certify to the
36 board that the health benefits plans to be used by the carrier are in
37 substantial compliance with the provisions in the corresponding board
38 approved plans. The certification shall be signed by the chief
39 executive officer of the carrier. Upon receipt by the board of the
40 certification, the certified plans may be used until the board, after
41 notice and hearing, disapproves their continued use.
42 e. Effective immediately for an individual health benefits plan
43 issued on or after the effective date of P.L.1995, c.316
44 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
45 date of an individual health benefits plan in effect on the effective date
46 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 [section] subsection. This [section] 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. (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. (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)

1 8. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
2 read as follows:
3 3. a. Except as provided in subsection f. of this section, every
4 small employer carrier shall, as a condition of transacting business in
5 this State, offer to every small employer the five health benefit plans
6 as provided in this section. The board shall establish a standard policy
7 form for each of the five plans, which except as otherwise provided in
8 subsection j. of this section, shall be the only plans offered to small
9 groups on or after January 1, 1994. One policy form shall contain the
10 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
11 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
12 carriers, one policy form shall be established which contains benefits
13 and cost sharing levels which are equivalent to the health benefits
14 plans of health maintenance organizations pursuant to the "Health
15 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
16 s.300e et seq.). The remaining policy forms shall contain basic hospital
17 and medical-surgical benefits, including, but not limited to:
18 (1) Basic inpatient and outpatient hospital care;
19 (2) Basic and extended medical-surgical benefits;
20 (3) Diagnostic tests, including X-rays;
21 (4) Maternity benefits, including prenatal and postnatal care; and
22 (5) Preventive medicine, including periodic physical examinations
23 and inoculations.
24 At least three of the forms shall provide for major medical benefits
25 in varying lifetime aggregates, one of which shall provide at least
26 $1,000,000 in lifetime aggregate benefits. The policy forms provided
27 pursuant to this section shall contain benefits representing
28 progressively greater actuarial values.
29 Notwithstanding the provisions of this subsection to the contrary,
30 the board also may establish additional policy forms by which a small
31 employer carrier, other than a health maintenance organization, may
32 provide indemnity benefits for health maintenance organization
33 enrollees by direct contract with the enrollees' small employer through
34 a dual arrangement with the health maintenance organization. The
35 dual arrangement shall be filed with the commissioner for approval.
36 The additional policy forms shall be consistent with the general
37 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).
38 b. Initially, a carrier shall offer a plan within 90 days of the
39 approval of such plan by the commissioner. Thereafter, the plans shall
40 be available to all small employers on a continuing basis. Every small
41 employer which elects to be covered under any health benefits plan
42 who pays the premium therefor and who satisfies the participation
43 requirements of the plan shall be issued a policy or contract by the
44 carrier.
45 c. The carrier may establish a premium payment plan which
46 provides installment payments and which may contain reasonable

1 provisions to ensure payment security, provided that provisions to
2 ensure payment security are uniformly applied.
3 d. In addition to the five standard policies described in subsection
4 a. of this section, the board may develop up to five rider packages.
5 Any such package which a carrier chooses to offer shall be issued to
6 a small employer who pays the premium therefor, and shall be subject
7 to the rating methodology set forth in section 9 of P.L.1992, c.162
8 (C.17B:27A-25).
9 e. Notwithstanding the provisions of subsection a. of this section
10 to the contrary, the board may approve a health benefits plan
11 containing only medical-surgical benefits or major medical expense
12 benefits, or a combination thereof, which is issued as a separate policy
13 in conjunction with a contract of insurance for hospital expense
14 benefits issued by a hospital service corporation, if the health benefits
15 plan and hospital service corporation contract combined otherwise
16 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et
17 seq.). Deductibles and coinsurance limits for the contract combined
18 may be allocated between the separate contracts at the discretion of
19 the carrier and the hospital service corporation.
20 f. Notwithstanding the provisions of this section to the contrary,
21 a health maintenance organization which is a qualified health
22 maintenance organization pursuant to the "Health Maintenance
23 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)
24 shall be permitted to offer health benefits plans formulated by the
25 board and approved by the commissioner which are in accordance with
26 the provisions of that law in lieu of the five plans required pursuant to
27 this section.
28 Notwithstanding the provisions of this section to the contrary, a
29 health maintenance organization which is approved pursuant to
30 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
31 benefits plans formulated by the board and approved by the
32 commissioner which are in accordance with the provisions of that law
33 in lieu of the five plans required pursuant to this section, except that
34 the plans shall provide the same level of benefits as required for a
35 federally qualified health maintenance organization, including any
36 requirements concerning copayments by enrollees.
37 g. A carrier shall not be required to own or control a health
38 maintenance organization or otherwise affiliate with a health
39 maintenance organization in order to comply with the provisions of
40 this section, but the carrier shall be required to offer the five health
41 benefits plans which are formulated by the board and approved by the
42 commissioner, including one plan which contains benefits and cost
43 sharing levels that are equivalent to those required for health
44 maintenance organizations.
45 h. Notwithstanding the provisions of subsection a. of this section
46 to the contrary, the board may modify the benefits provided for in

1 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2
2 and 26:2J-4.3).
3 i. (1) In addition to the rider packages provided for in subsection d.
4 of this section, every carrier may offer, in connection with the five
5 health benefits plans required to be offered by this section, any number
6 of riders which may revise the coverage offered by the five plans in
7 any way, provided, however, that any form of such rider or
8 amendment thereof which decreases benefits or decreases the actuarial
9 value of one of the five plans shall be filed for informational purposes
10 with the board and for approval by the commissioner before such rider
11 may be sold. Any rider or amendment thereof which adds benefits or
12 increases the actuarial value of one of the five plans shall be filed with
13 the board for informational purposes before such rider may be sold.
14 The commissioner shall disapprove any rider filed pursuant to this
15 subsection that is unjust, unfair, inequitable, unreasonably
16 discriminatory, misleading, contrary to law or the public policy of this
17 State. The commissioner shall not approve any rider which reduces
18 benefits below those required by sections 55, 57 and 59 of P.L.1991,
19 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be
20 sold pursuant to this section. The commissioner's determination shall
21 be in writing and shall be appealable.
22 (2) The benefit riders provided for in paragraph (1) of this
23 subsection shall be subject to the provisions of section 2, subsection
24 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
25 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23,
26 17B:27A-24, 17B:27A-25, and 17B:27A-27).
27 j. (1) Notwithstanding the provisions of P.L.1992, c.162
28 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
29 by or through a carrier, association, multiple employer arrangement
30 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
31 paragraph (6) of this subsection are met, issued by or through an
32 out-of-State trust prior to January 1, 1994, at the option of a small
33 employer policy or contract holder, may be renewed or continued after
34 February 28, 1994, or in the case of such a health benefits plan whose
35 anniversary date occurred between March 1, 1994 and the effective
36 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
37 within 60 days of that anniversary date and renewed or continued if,
38 beginning on the first 12-month anniversary date occurring on or after
39 the sixtieth day after the board adopts regulations concerning the
40 implementation of the rating factors permitted by section 9 of
41 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
42 delivery of the health benefits plan, the health benefits plan renewed,
43 continued or reinstated pursuant to this subsection complies with the
44 provisions of section 2, subsection b. of section 3, and sections 6, 7,
45 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
46 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and

17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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 [burder] 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.

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

(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)

1 of this paragraph, a health benefits plan renewed, continued or
2 reinstated pursuant to this subsection shall be filed with the
3 commissioner for informational purposes within 30 days after its
4 renewal date. No later than 60 days after the board adopts regulations
5 concerning the implementation of the rating factors permitted by
6 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
7 amended to show any modifications in the plan that are necessary to
8 comply with the provisions of this subsection. The commissioner shall
9 monitor compliance of any such plan with the requirements of this
10 subsection, except that the board shall enforce the loss ratio
11 requirements.
12 (b) A health benefits plan filed with the commissioner pursuant to
13 subparagraph (a) of this paragraph may be amended as to its benefit
14 structure if the amendment does not reduce the actuarial value and
15 benefits coverage of the health benefits plan below that of the lowest
16 standard health benefits plan established by the board pursuant to
17 subsection a. of this section. The amendment shall be filed with the
18 commissioner for approval pursuant to the terms of sections 4, 8, 12
19 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
20 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
21 shall comply with the provisions of sections 2 and 9 of P.L.1992,
22 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
23 c.340 (C.17B:27A-19.3).
24 (c) A health benefits plan issued by a carrier through an
25 out-of-State trust shall be permitted to be renewed or continued
26 pursuant to paragraph (1) of this subsection upon approval by the
27 commissioner and only if the benefits offered under the plan are at
28 least equal to the actuarial value and benefits coverage of the lowest
29 standard health benefits plan established by the board pursuant to
30 subsection a. of this section. For the purposes of meeting the
31 requirements of this subparagraph, carriers shall be required to file
32 with the commissioner the health benefits plans issued through an
33 out-of-State trust no later than 180 days after the date of enactment
34 of P.L.1995, c.340. A health benefits plan issued by a carrier through
35 an out-of-State trust that is not filed with the commissioner pursuant
36 to this subparagraph, shall not be permitted to be continued or
37 renewed after the 180-day period.
38 (7) Notwithstanding the provisions of P.L.1992, c.162
39 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
40 employer arrangement or out-of-State trust may offer a health benefits
41 plan authorized to be renewed, continued or reinstated pursuant to this
42 subsection to small employer groups that are otherwise eligible
43 pursuant to paragraph (1) of subsection j. of this section during the
44 period for which such health benefits plan is otherwise authorized to
45 be renewed, continued or reinstated.

1 (8) Notwithstanding the provisions of P.L.1992, c.162
2 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
3 employer arrangement or out-of-State trust may offer coverage under
4 a health benefits plan authorized to be renewed, continued or
5 reinstated pursuant to this subsection to new employees of small
6 employer groups covered by the health benefits plan in accordance
7 with the provisions of paragraph (1) of this subsection.
8 (9) Notwithstanding the provisions of P.L.1992, c.162
9 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
10 the contrary, any individual, who is eligible for small employer
11 coverage under a policy issued, renewed, continued or reinstated
12 pursuant to this subsection, but who would be subject to a preexisting
13 condition exclusion under the small employer health benefits plan, or
14 who is a member of a small employer group who has been denied
15 coverage under the small employer group health benefits plan for
16 health reasons, may elect to purchase or continue coverage under an
17 individual health benefits plan until such time as the group health
18 benefits plan covering the small employer group of which the
19 individual is a member complies with the provisions of P.L.1992, c.162
20 (C.17B:27A-17 et seq.).
21 (10) In a case in which an association made available a health
22 benefits plan on or before March 1, 1994 and subsequently changed
23 the issuing carrier between March 1, 1994 and the effective date of
24 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
25 eligible to continue and renew the plan pursuant to paragraph (1) of
26 this subsection.
27 (11) In a case in which an association, multiple employer
28 arrangement or out-of-State trust made available a health benefits plan
29 on or before March 1, 1994 and subsequently changes the issuing
30 carrier for that plan after the effective date of P.L.1995, c.340, the
31 new issuing carrier shall file the health benefits plan with the
32 commissioner for approval in order to be deemed eligible to continue
33 and renew that plan pursuant to paragraph (1) of this subsection.
34 (12) In a case in which a small employer purchased a health
35 benefits plan directly from a carrier on or before March 1, 1994 and
36 subsequently changes the issuing carrier for that plan after the
37 effective date of P.L.1995, c.340, the new issuing carrier shall file the
38 health benefits plan with the commissioner for approval in order to be
39 deemed eligible to continue and renew that plan pursuant to paragraph
40 (1) of this subsection.
41 Notwithstanding the provisions of subparagraph (b) of paragraph
42 (6) of this subsection to the contrary, a small employer who changes
43 its health benefits plan's issuing carrier pursuant to the provisions of
44 this paragraph, shall not, upon changing carriers, modify the benefit
45 structure of that health benefits plan within six months of the date the
46 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 State 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. , c. (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. (C.)(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

1 may be subject to utilization review, including periodic review, of the
2 continued medical necessity of the specialized infant formula.
3 The benefits shall be provided to the same extent as for any other
4 prescribed items under the health benefits plan.
5 This subsection shall apply to all small employer health benefits
6 plans in which the carrier has reserved the right to change the
7 premium.
8 (cf: P.L.1997, c.419, s.6)
9
10 9. This act shall take effect on the 60th day following enactment.
11
12
13 STATEMENT
14
15 This bill requires hospital, medical and health service corporations,
16 individual, small employer and large group insurers and health
17 maintenance organizations to provide coverage for certain specialized
18 infant formulas. Infants who suffer from multiple food protein
19 intolerance and are not responsive to standard non-cow milk-based
20 formulas require specialty formulas. The cost of these specialty
21 formulas, such as Neocate, is more than two and a half times the
22 average cost of standard infant formulas. Although these specialty
23 formulas are only administered under a physician's supervision, they
24 are not classified as prescription drugs.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3976

STATE OF NEW JERSEY

DATED: DECEMBER 13, 2001

The Assembly Banking and Insurance Committee reports favorably Assembly Bill No. 3976.

This bill requires health insurance carriers, including hospital, medical and health service corporations, commercial individual and group health insurers, health maintenance organizations and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs that offer prescription drug benefits, to provide benefits for expenses incurred in the purchase of certain infant formulas.

The bill specifies that benefits shall be provided for 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 bill also provides that the coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

§1 - C.17:48-6z
§2 - C.17:48A-7y
§3 - C.17:48E-35.24
§4 - C.17B:27-46.1z
§5 - C.17B:26-2.1v
§6 - C.26:2J-4.25
§9 - Note to
§§1-8

P.L. 2001, CHAPTER 361, ***approved January 6, 2002***
Senate, No. 1839 ***(First Reprint)***

1 **AN ACT** concerning coverage of certain infant formulas,
2 supplementing Titles 17 and 26 of the Revised Statutes and Title
3 17B of the New Jersey Statutes, and amending P.L.1992, c.161 and
4 P.L.1992, c.162.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) A hospital service corporation which provides
10 hospital or medical expense benefits [1]for expenses incurred in the
11 purchase of prescription drugs[1] under a contract that is delivered,
12 issued, executed or renewed in this State, or approved for issuance or
13 renewal in this State by the Commissioner of Banking and Insurance
14 on or after the effective date of this act, shall provide benefits under
15 the contract for expenses incurred in the purchase of specialized [1]non-
16 standard[1] infant formulas, when the covered infant's physician has
17 diagnosed the infant as having [1]**[**cow milk allergy and**]**[1] multiple food
18 protein intolerance and has determined such formula to be medically
19 necessary[1], and when the covered infant has not been responsive to
20 trials of standard non-cow milk-based formulas, including soybean and
21 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[1].
24 The benefits shall be provided to the same extent as for any other
25 [1]**[**medical condition**]** prescribed items[1] 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
30 2. (New section) A medical service corporation which provides
31 hospital or medical expense benefits [1]for expenses incurred in the
32 purchase of prescription drugs[1] under a contract that is delivered,
33 issued, executed or renewed in this State, or approved for issuance or
34 renewal in this State by the Commissioner of Banking and Insurance

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted January 22, 2001.

on or after the effective date of this act, shall provide benefits under the contract for expenses incurred in the purchase of specialized [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1][cow milk allergy and][1] multiple food protein intolerance and has determined such formula to be medically necessary[1], 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[1].

The benefits shall be provided to the same extent as for any other [1][medical condition] prescribed items[1] 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 [1]for expenses incurred in the purchase of prescription drugs[1] 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 [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1][cow milk allergy and][1] multiple food protein intolerance and has determined such formula to be medically necessary[1], 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[1].

The benefits shall be provided to the same extent as for any other [1][medical condition] prescribed items[1] 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 [1]for expenses incurred in the purchase of prescription drugs[1] 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 [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1][cow milk allergy and][1] multiple food protein intolerance

and has determined such formula to be medically necessary[1], 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[1].

The benefits shall be provided to the same extent as for any other [1][medical condition] prescribed items[1] 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 [1]for expenses incurred in the purchase of prescription drugs[1] 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 [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1][cow milk allergy and][1] multiple food protein intolerance and has determined such formula to be medically necessary[1], 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[1].

The benefits shall be provided to the same extent as for any other [1][medical condition] prescribed items[1] 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 [1]that provides health care services for prescription drugs under a contract[1], unless the health maintenance organization also provides health care services in the purchase of specialized [1]non-standard[1] infant formulas, when the covered infant's physician has diagnosed the infant as having [1][cow milk allergy and][1] multiple food protein intolerance and has determined such formula to be medically necessary[1], 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[1].

The health care services shall be provided to the same extent as for

1 any other [1][medical condition] prescribed items[1] under the contract.
2 The provisions of this section shall apply to those contracts for
3 health care services by health maintenance organizations under which
4 the health maintenance organization has reserved the right to change
5 the schedule of charges for enrollee coverage.
6
7 7. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
8 read as follows:
9 6. The board shall establish the policy and contract forms and
10 benefit levels to be made available by all carriers for the health benefits
11 plans required to be issued pursuant to section 3 of P.L.1992, c.161
12 (C.17B:27A-4), and shall adopt such modifications to one or more
13 plans as the board determines are necessary to make available a "high
14 deductible health plan" or plans consistent with section 301 of Title III
15 of the "Health Insurance Portability and Accountability Act of 1996,"
16 Pub.L.104-191, regarding tax-deductible medical savings accounts,
17 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
18 al.). The board shall provide the commissioner with an informational
19 filing of the policy and contract forms and benefit levels it establishes.
20 a. The individual health benefits plans established by the board
21 may include cost containment measures such as, but not limited to:
22 utilization review of health care services, including review of medical
23 necessity of hospital and physician services; case management benefit
24 alternatives; selective contracting with hospitals, physicians, and other
25 health care providers; and reasonable benefit differentials applicable to
26 participating and nonparticipating providers; and other managed care
27 provisions.
28 b. An individual health benefits plan offered pursuant to section
29 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
30 more than 12 months on coverage for preexisting conditions. An
31 individual health benefits plan offered pursuant to section 3 of
32 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
33 condition limitation of any period under the following circumstances:
34 (1) to an individual who has, under creditable coverage, with no
35 intervening lapse in coverage of more than 31 days, been treated or
36 diagnosed by a physician for a condition under that plan or satisfied a
37 12-month preexisting condition limitation; or
38 (2) to a federally defined eligible individual who applies for an
39 individual health benefits plan within 63 days of termination of the
40 prior coverage.
41 c. In addition to the five standard individual health benefits plans
42 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
43 may develop up to five rider packages. Premium rates for the rider
44 packages shall be determined in accordance with section 8 of
45 P.L.1992, c.161 (C.17B:27A-9).
46 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 [section] subsection. This [section] 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. (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. (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) [1]that provide benefits for expenses incurred in the purchase of prescription drugs[1] shall provide benefits for expenses incurred in the purchase of

1 specialized [1]non-standard[1] infant formulas, when the covered infant's
2 physician has diagnosed the infant as having [1][cow milk allergy and][1]
3 multiple food protein intolerance and has determined such formula to
4 be medically necessary[1], and when the covered infant has not been
5 responsive to trials of standard non-cow milk-based formulas,
6 including soybean and goat milk. The coverage may be subject to
7 utilization review, including periodic review, of the continued medical
8 necessity of the specialized infant formula[1].
9 The benefits shall be provided to the same extent as for any other
10 [1][medical condition] prescribed items[1] under the health benefits plan.
11 This subsection shall apply to all individual health benefits plans in
12 which the carrier has reserved the right to change the premium.
13 (cf: P.L.1997, c.414, s.1)
14
15 8. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
16 read as follows:
17 3. a. Except as provided in subsection f. of this section, every
18 small employer carrier shall, as a condition of transacting business in
19 this State, offer to every small employer the five health benefit plans
20 as provided in this section. The board shall establish a standard policy
21 form for each of the five plans, which except as otherwise provided in
22 subsection j. of this section, shall be the only plans offered to small
23 groups on or after January 1, 1994. One policy form shall contain the
24 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
25 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
26 carriers, one policy form shall be established which contains benefits
27 and cost sharing levels which are equivalent to the health benefits
28 plans of health maintenance organizations pursuant to the "Health
29 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
30 s.300e et seq.). The remaining policy forms shall contain basic hospital
31 and medical-surgical benefits, including, but not limited to:
32 (1) Basic inpatient and outpatient hospital care;
33 (2) Basic and extended medical-surgical benefits;
34 (3) Diagnostic tests, including X-rays;
35 (4) Maternity benefits, including prenatal and postnatal care; and
36 (5) Preventive medicine, including periodic physical examinations
37 and inoculations.
38 At least three of the forms shall provide for major medical benefits
39 in varying lifetime aggregates, one of which shall provide at least
40 $1,000,000 in lifetime aggregate benefits. The policy forms provided
41 pursuant to this section shall contain benefits representing
42 progressively greater actuarial values.
43 Notwithstanding the provisions of this subsection to the contrary,
44 the board also may establish additional policy forms by which a small
45 employer carrier, other than a health maintenance organization, may
46 provide indemnity benefits for health maintenance organization

1 enrollees by direct contract with the enrollees' small employer through
2 a dual arrangement with the health maintenance organization. The
3 dual arrangement shall be filed with the commissioner for approval.
4 The additional policy forms shall be consistent with the general
5 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).
6 b. Initially, a carrier shall offer a plan within 90 days of the
7 approval of such plan by the commissioner. Thereafter, the plans shall
8 be available to all small employers on a continuing basis. Every small
9 employer which elects to be covered under any health benefits plan
10 who pays the premium therefor and who satisfies the participation
11 requirements of the plan shall be issued a policy or contract by the
12 carrier.
13 c. The carrier may establish a premium payment plan which
14 provides installment payments and which may contain reasonable
15 provisions to ensure payment security, provided that provisions to
16 ensure payment security are uniformly applied.
17 d. In addition to the five standard policies described in subsection
18 a. of this section, the board may develop up to five rider packages.
19 Any such package which a carrier chooses to offer shall be issued to
20 a small employer who pays the premium therefor, and shall be subject
21 to the rating methodology set forth in section 9 of P.L.1992, c.162
22 (C.17B:27A-25).
23 e. Notwithstanding the provisions of subsection a. of this section
24 to the contrary, the board may approve a health benefits plan
25 containing only medical-surgical benefits or major medical expense
26 benefits, or a combination thereof, which is issued as a separate policy
27 in conjunction with a contract of insurance for hospital expense
28 benefits issued by a hospital service corporation, if the health benefits
29 plan and hospital service corporation contract combined otherwise
30 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et
31 seq.). Deductibles and coinsurance limits for the contract combined
32 may be allocated between the separate contracts at the discretion of
33 the carrier and the hospital service corporation.
34 f. Notwithstanding the provisions of this section to the contrary,
35 a health maintenance organization which is a qualified health
36 maintenance organization pursuant to the "Health Maintenance
37 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)
38 shall be permitted to offer health benefits plans formulated by the
39 board and approved by the commissioner which are in accordance with
40 the provisions of that law in lieu of the five plans required pursuant to
41 this section.
42 Notwithstanding the provisions of this section to the contrary, a
43 health maintenance organization which is approved pursuant to
44 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
45 benefits plans formulated by the board and approved by the
46 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 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3).

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 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

1 employer policy or contract holder, may be renewed or continued after
2 February 28, 1994, or in the case of such a health benefits plan whose
3 anniversary date occurred between March 1, 1994 and the effective
4 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
5 within 60 days of that anniversary date and renewed or continued if,
6 beginning on the first 12-month anniversary date occurring on or after
7 the sixtieth day after the board adopts regulations concerning the
8 implementation of the rating factors permitted by section 9 of
9 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
10 delivery of the health benefits plan, the health benefits plan renewed,
11 continued or reinstated pursuant to this subsection complies with the
12 provisions of section 2, subsection b. of section 3, and sections 6, 7,
13 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
14 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
15 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).
16 Nothing in this subsection shall be construed to require an
17 association, multiple employer arrangement or out-of-State trust to
18 provide health benefits coverage to small employers that are not
19 contemplated by the organizational documents, bylaws, or other
20 regulations governing the purpose and operation of the association,
21 multiple employer arrangement or out-of-State trust. Notwithstanding
22 the foregoing provision to the contrary, an association, multiple
23 employer arrangement or out-of-State trust that offers health benefits
24 coverage to its members' employees and dependents:
25 (a) shall offer coverage to all eligible employees and their
26 dependents within the membership of the association, multiple
27 employer arrangement or out-of-State trust;
28 (b) shall not use actual or expected health status in determining its
29 membership; and
30 (c) shall make available to its small employer members at least one
31 of the standard benefits plans, as determined by the commissioner, in
32 addition to any health benefits plan permitted to be renewed or
33 continued pursuant to this subsection.
34 (2) Notwithstanding the provisions of this subsection to the
35 contrary, a carrier or out-of-State trust which writes the health
36 benefits plans required pursuant to subsection a. of this section shall
37 be required to offer those plans to any small employer, association or
38 multiple employer arrangement.
39 (3) (a) A carrier, association, multiple employer arrangement or
40 out-of-State trust may withdraw a health benefits plan marketed to
41 small employers that was in effect on December 31, 1993 with the
42 approval of the commissioner. The commissioner shall approve a
43 request to withdraw a plan, consistent with regulations adopted by the
44 commissioner, only on the grounds that retention of the plan would
45 cause an unreasonable financial [burder] <u>burden</u> to the issuing carrier,
46 taking into account the rating provisions of section 9 of P.L.1992,

1 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
2 (C.17B:27A-19.3).
3 (b) A carrier which has renewed, continued or reinstated a health
4 benefits plan pursuant to this subsection that has not been newly issued
5 to a new small employer group since January 1, 1994, may, upon
6 approval of the commissioner, continue to establish its rates for that
7 plan based on the loss experience of that plan if the carrier does not
8 issue that health benefits plan to any new small employer groups.
9 (4) (Deleted by amendment, P.L.1995, c.340).
10 (5) A health benefits plan that otherwise conforms to the
11 requirements of this subsection shall be deemed to be in compliance
12 with this subsection, notwithstanding any change in the plan's
13 deductible or copayment.
14 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
15 of this paragraph, a health benefits plan renewed, continued or
16 reinstated pursuant to this subsection shall be filed with the
17 commissioner for informational purposes within 30 days after its
18 renewal date. No later than 60 days after the board adopts regulations
19 concerning the implementation of the rating factors permitted by
20 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
21 amended to show any modifications in the plan that are necessary to
22 comply with the provisions of this subsection. The commissioner shall
23 monitor compliance of any such plan with the requirements of this
24 subsection, except that the board shall enforce the loss ratio
25 requirements.
26 (b) A health benefits plan filed with the commissioner pursuant to
27 subparagraph (a) of this paragraph may be amended as to its benefit
28 structure if the amendment does not reduce the actuarial value and
29 benefits coverage of the health benefits plan below that of the lowest
30 standard health benefits plan established by the board pursuant to
31 subsection a. of this section. The amendment shall be filed with the
32 commissioner for approval pursuant to the terms of sections 4, 8, 12
33 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
34 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
35 shall comply with the provisions of sections 2 and 9 of P.L.1992,
36 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
37 c.340 (C.17B:27A-19.3).
38 (c) A health benefits plan issued by a carrier through an
39 out-of-State trust shall be permitted to be renewed or continued
40 pursuant to paragraph (1) of this subsection upon approval by the
41 commissioner and only if the benefits offered under the plan are at
42 least equal to the actuarial value and benefits coverage of the lowest
43 standard health benefits plan established by the board pursuant to
44 subsection a. of this section. For the purposes of meeting the
45 requirements of this subparagraph, carriers shall be required to file
46 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.

1 (12) In a case in which a small employer purchased a health benefits
2 plan directly from a carrier on or before March 1, 1994 and
3 subsequently changes the issuing carrier for that plan after the
4 effective date of P.L.1995, c.340, the new issuing carrier shall file the
5 health benefits plan with the commissioner for approval in order to be
6 deemed eligible to continue and renew that plan pursuant to paragraph
7 (1) of this subsection.
8 Notwithstanding the provisions of subparagraph (b) of paragraph
9 (6) of this subsection to the contrary, a small employer who changes
10 its health benefits plan's issuing carrier pursuant to the provisions of
11 this paragraph, shall not, upon changing carriers, modify the benefit
12 structure of that health benefits plan within six months of the date the
13 issuing carrier was changed.
14 k. Effective immediately for a health benefits plan issued on or
15 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and
16 effective on the first 12-month anniversary date of a health benefits
17 plan in effect on the effective date of P.L.1995, c.316
18 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to
19 this section, including any plans offered by a State approved or
20 federally qualified health maintenance organization, shall contain
21 benefits for expenses incurred in the following:
22 (1) Screening by blood lead measurement for lead poisoning for
23 children, including confirmatory blood lead testing as specified by the
24 Department of Health and Senior Services pursuant to section 7 of
25 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
26 necessary medical follow-up and treatment for lead poisoned children.
27 (2) All childhood immunization as recommended by the Advisory
28 Committee on Immunization Practices of the United State Public
29 Health Service and the Department of Health and Senior Services
30 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
31 shall notify its insureds, in writing, of any change in the health care
32 services provided with respect to childhood immunizations and any
33 related changes in premium. Such notification shall be in a form and
34 manner to be determined by the Commissioner of Banking and
35 Insurance.
36 The benefits shall be provided to the same extent as for any other
37 medical condition under the health benefits plan, except that no
38 deductible shall be applied for benefits provided pursuant to this
39 [section] <u>subsection</u>. This [section] <u>subsection</u> shall apply to all
40 small employer health benefits plans in which the carrier has reserved
41 the right to change the premium.
42 l. The board shall consider including benefits for speech-language
43 pathology and audiology services, as rendered by speech-language
44 pathologists and audiologists within the scope of their practices, in at
45 least one of the five standard policies and in at least one of the five
46 riders to be developed under this section.

1 m. Effective immediately for a health benefits plan issued on or
2 after the effective date of P.L. , c. (C.)(pending before the
3 Legislature as this bill) and effective on the first 12-month anniversary
4 date of a health benefits plan in effect on the effective date of P.L. ,
5 c. (C.)(pending before the Legislature as this bill), the health
6 benefits plans required pursuant to this section [1]that provide benefits
7 for expenses incurred in the purchase of prescription drugs[1] shall
8 provide benefits for expenses incurred in the purchase of specialized
9 [1]non-standard[1] infant formulas, when the covered infant's physician
10 has diagnosed the infant as having [1][cow milk allergy and][1] multiple
11 food protein intolerance and has determined such formula to be
12 medically necessary[1], and when the covered infant has not been
13 responsive to trials of standard non-cow milk-based formulas,
14 including soybean and goat milk. The coverage may be subject to
15 utilization review, including periodic review, of the continued medical
16 necessity of the specialized infant formula[1].
17 The benefits shall be provided to the same extent as for any other
18 [1][medical condition] prescribed items[1] under the health benefits plan.
19 This subsection shall apply to all small employer health benefits
20 plans in which the carrier has reserved the right to change the
21 premium.
22 (cf: P.L.1997, c.419, s.6)
23
24 9. This act shall take effect [1][immediately] on the 60th day
25 following enactment[1].
26
27
28 ______________
29
30 Mandates health insurance coverage for certain infant formulas.

CHAPTER 361

AN ACT concerning coverage of certain infant formulas, supplementing Titles 17 and 26 of the Revised Statutes and Title 17B of the New Jersey Statutes, and amending P.L.1992, c.161 and P.L.1992, c.162.

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

C.17:48-6z Hospital service corporation prescription drug plans to cover certain infant formulas.

1. 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.

C.17:48A-7y Medical service corporation prescription drug plans to cover certain infant formulas.

2. 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 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.

C.17:48E-35.24 Health service corporation prescription drug plans to cover certain infant formulas.

3. 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.

C.17B:27-46.1z Group health insurer prescription drug plans to cover certain infant formulas.

4. 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.

C.17B:26-2.1v Individual health insurer prescription drug plans to cover certain infant formulas.

5. 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.

C.26:2J-4.25 Health maintenance organization prescription drug plans to cover certain infant formulas.

6. 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 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 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:

C.17B:27A-7 Establishment of policy, contract forms; high deductible health plan; benefit levels.

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

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

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

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

C.17B:27A-19 Five health benefit plans offered to small employers; exceptions.

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 ensure 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 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e 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.

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 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3).

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 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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.

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

(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 State 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 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.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to 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.

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

Approved January 6, 2002.