

17:48E-35.10

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2005 **CHAPTER:** 248

NJSA: 17:48E-35.10 (Concerns certain high deductible health plans)

BILL NO: A4543 (Substituted for S2574/2435)

SPONSOR(S): Cohen and Russo

DATE INTRODUCED: December 12, 2005

COMMITTEE: **ASSEMBLY:**

SENATE:

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** December 12, 2005

SENATE: December 15, 2005

DATE OF APPROVAL: December 21, 2005

FOLLOWING ARE ATTACHED IF AVAILABLE:

[FINAL TEXT OF BILL](#) (Original version of bill enacted)

A4543

[SPONSOR'S STATEMENT](#): (Begins on page 27 of original bill) [Yes](#)

COMMITTEE STATEMENT: **ASSEMBLY:** No

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

S2574/2435

[SPONSOR'S STATEMENT \(S2574\)](#): (Begins on page 16 of original bill) [Yes](#)

[SPONSOR'S STATEMENT \(S2435\)](#): (Begins on page 15 of original bill) [Yes](#)

COMMITTEE STATEMENT: **ASSEMBLY:** No

[SENATE:](#) [Yes](#)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

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REPORTS:

No

HEARINGS:

No

NEWSPAPER ARTICLES:

No

IS 11/29/07

§§2,3 -
C.17:48E-35.27 &
17:48E-35.28
§§5,6 - C.17:48-6cc
& 17:48-6dd
§§8,9 -
C.17B:27-46.1cc &
17B:27-46.1dd
§§11,12 -
C.26:2J-4.28 &
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§17 -
C.17B:27A-19a
§§18,19 -
C.17B:27A-55 &
17B:27A-56
§21 - C.30:4J-12.1
§22 - C.26:2H-18.71
§23 - T&E
§24 - Note to §§1-23

P.L. 2005, CHAPTER 248, *approved December 21, 2005*
Assembly, No. 4543

1 **AN ACT** concerning certain high deductible health plans and amending
2 and supplementing various parts of the statutory law.

3

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

6

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

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

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

22 b. All childhood immunizations as recommended by the Advisory

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

Matter underlined thus is new matter.

1 Committee on Immunization Practices of the United States Public
2 Health Service and the Department of Health and Senior Services
3 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
4 service corporation shall notify its subscribers, in writing, of any
5 change in coverage with respect to childhood immunizations and any
6 related changes in premium. Such notification shall be in a form and
7 manner to be determined by the Commissioner of Banking and
8 Insurance.

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

16 The benefits provided pursuant to this section shall be provided to
17 the same extent as for any other medical condition under the contract,
18 except that ~~[no] a deductible shall not be applied for benefits provided~~
19 ~~pursuant to this section; however, with respect to a contract that~~
20 ~~qualifies as a high deductible health plan for which qualified medical~~
21 ~~expenses are paid using a health savings account established pursuant~~
22 ~~to section 223 of the federal Internal Revenue Code of 1986 (26~~
23 ~~U.S.C. s.223), a deductible shall not be applied for any benefits~~
24 ~~provided pursuant to this section which represent preventive care as~~
25 ~~permitted by that federal law, and shall not be applied as provided~~
26 ~~pursuant to section 3 of P.L. , c. (C.) (pending before the~~
27 ~~Legislature as this bill) . This section shall apply to all health service~~
28 ~~corporation contracts in which the health service corporation has~~
29 ~~reserved the right to change the premium.~~
30 (cf: P.L.2001, c.373, s.10)

31
32 2. (New section) No health service corporation contract providing
33 hospital or medical expense benefits for groups with greater than 50
34 persons, that qualifies as a high deductible health plan for which
35 qualified medical expenses are paid using a health savings account
36 established pursuant to section 223 of the federal Internal Revenue
37 Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed
38 or renewed in this State, or approved for issuance or renewal in this
39 State by the Commissioner of Banking and Insurance on or after the
40 effective date of P.L. , c. (C.) (pending before the
41 Legislature as this bill), unless the contract provides benefits to any
42 named subscriber or other person covered thereunder for expenses
43 incurred in connection with any medically necessary benefits provided
44 in-network that represent preventive care as permitted by that federal
45 law.

46 The benefits provided pursuant to this section shall be provided to

1 the same extent as for any other medical condition under the contract,
2 except that a deductible shall not be applied for benefits provided
3 pursuant to this section. This section shall apply to all health service
4 corporation contracts in which the health service corporation has
5 reserved the right to change the premium.

6
7 3. (New Section) Notwithstanding the provisions of section 1 of
8 P.L.1995, c.316 (C.17:48E-35.10) regarding deductibles for a high
9 deductible health plan, a contract offered by a health service
10 corporation providing hospital or medical expense benefits for groups
11 with greater than 50 persons, that qualifies as a high deductible health
12 plan for which qualified medical expenses are paid using a health
13 savings account established pursuant to section 223 of the federal
14 Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is
15 delivered, issued, executed or renewed in this State, or approved for
16 issuance or renewal in this State by the Commissioner of Banking and
17 Insurance on or after the effective date of P.L. , c. (C.)
18 (pending before the Legislature as this bill), shall not apply a
19 deductible for any benefits for which a deductible is not applicable
20 pursuant to any law enacted after the effective date of P.L. , c.
21 (C.) (pending before the Legislature as this bill).

22 This section shall apply to all health service corporation contracts
23 in which the health service corporation has reserved the right to
24 change the premium.

25
26 4. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
27 as follows:

28 2. No hospital service corporation contract providing hospital or
29 medical expense benefits for groups with greater than 50 persons shall
30 be delivered, issued, executed or renewed in this State, or approved
31 for issuance or renewal in this State by the Commissioner of Banking
32 and Insurance on or after the effective date of [this act] P.L. , c.
33 (C.) (pending before the Legislature as this bill), unless the
34 contract provides benefits to any named subscriber or other person
35 covered thereunder for expenses incurred in the following:

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

41 b. All childhood immunizations as recommended by the Advisory
42 Committee on Immunization Practices of the United State Public
43 Health Service and the Department of Health and Senior Services
44 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
45 service corporation shall notify its subscribers, in writing, of any
46 change in coverage with respect to childhood immunizations and any

1 related changes in premium. Such notification shall be in a form and
2 manner to be determined by the Commissioner of Banking and
3 Insurance.

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

11 The benefits provided pursuant to this section shall be provided to
12 the same extent as for any other medical condition under the contract,
13 except that [no] a deductible shall not be applied for benefits provided
14 pursuant to this section; however, with respect to a contract that
15 qualifies as a high deductible health plan for which qualified medical
16 expenses are paid using a health savings account established pursuant
17 to section 223 of the federal Internal Revenue Code of 1986 (26
18 U.S.C. s.223), a deductible shall not be applied for any benefits
19 provided pursuant to this section which represent preventive care as
20 permitted by that federal law, and shall not be applied as provided
21 pursuant to section 6 of P.L. _____, c. _____ (C. _____) (pending before
22 the Legislature as this bill). This section shall apply to all hospital
23 service corporation contracts in which the health service corporation
24 has reserved the right to change the premium.

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

26

27 5. (New section) No hospital service corporation contract
28 providing hospital or medical expense benefits for groups with greater
29 than 50 persons, that qualifies as a high deductible health plan for
30 which qualified medical expenses are paid using a health savings
31 account established pursuant to section 223 of the federal Internal
32 Revenue Code of 1986 (26 U.S.C. s.223), shall be delivered, issued,
33 executed or renewed in this State, or approved for issuance or renewal
34 in this State by the Commissioner of Banking and Insurance on or after
35 the effective date of P.L. _____, c. _____ (C. _____) (pending before the
36 Legislature as this bill), unless the contract provides benefits to any
37 named subscriber or other person covered thereunder for expenses
38 incurred in connection with any medically necessary benefits provided
39 in-network that represent preventive care as permitted by that federal
40 law.

41 The benefits provided pursuant to this section shall be provided to
42 the same extent as for any other medical condition under the contract,
43 except that a deductible shall not be applied for benefits provided
44 pursuant to this section. This section shall apply to all hospital service
45 corporation contracts in which the hospital service corporation has
46 reserved the right to change the premium.

1 6. (New section) Notwithstanding the provisions of section 2 of
2 P.L.1995, c.316 (C.17:48-6m) regarding deductibles for a high
3 deductible health plan, a contract offered by a hospital service
4 corporation providing hospital or medical expense benefits for groups
5 with greater than 50 persons, that qualifies as a high deductible health
6 plan for which qualified medical expenses are paid using a health
7 savings account established pursuant to section 223 of the federal
8 Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is
9 delivered, issued, executed or renewed in this State, or approved for
10 issuance or renewal in this State by the Commissioner of Banking and
11 Insurance on or after the effective date of P.L. , c. (C.)
12 (pending before the Legislature as this bill), shall not apply a
13 deductible for any benefits for which a deductible is not applicable
14 pursuant to any law enacted after the effective date of P.L. , c.
15 (C.) (pending before the Legislature as this bill).

16 This section shall apply to all hospital service corporation contracts
17 in which the hospital service corporation has reserved the right to
18 change the premium.

19

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

22 3. No group health insurance policy providing hospital or medical
23 expense benefits for groups with more than 50 persons shall be
24 delivered, issued, executed or renewed in this State, or approved for
25 issuance or renewal in this State by the Commissioner of Banking and
26 Insurance on or after the effective date of [this act] P.L. , c.
27 (C.) (pending before the Legislature as this bill), unless the policy
28 provides benefits to any named insured or other person covered
29 thereunder for expenses incurred in the following:

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

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

43 c. Screening for newborn hearing loss by appropriate
44 electrophysiologic screening measures and periodic monitoring of
45 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
46 (C.26:2-103.1 et al.). Payment for this screening service shall be

1 separate and distinct from payment for routine new baby care in the
2 form of a newborn hearing screening fee as negotiated with the
3 provider and facility.

4 The benefits provided pursuant to this section shall be provided to
5 the same extent as for any other medical condition under the policy,
6 except that ~~[no] a deductible shall not~~ be applied for benefits provided
7 pursuant to this section; however, with respect to a policy that
8 qualifies as a high deductible health plan for which qualified medical
9 expenses are paid using a health savings account established pursuant
10 to section 223 of the federal Internal Revenue Code of 1986 (26
11 U.S.C. s.223), a deductible shall not be applied for any benefits
12 provided pursuant to this section that represent preventive care as
13 permitted by that federal law, and shall not be applied as provided
14 pursuant to section 9 of P.L. , c. (C.) (pending before the
15 Legislature as this bill). This section shall apply to all group health
16 insurance policies in which the health insurer has reserved the right to
17 change the premium.
18 (cf: P.L.2001, c.373, s.12)

19

20 8. (New section) No group health insurance policy providing
21 hospital or medical expense benefits for groups with more than 50
22 persons, that qualifies as a high deductible health plan for which
23 qualified medical expenses are paid using a health savings account
24 established pursuant to section 223 of the federal Internal Revenue
25 Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed
26 or renewed in this State, or approved for issuance or renewal in this
27 State by the Commissioner of Banking and Insurance on or after the
28 effective date of P.L. , c. (C.) (pending before the
29 Legislature as this bill), unless the policy provides benefits to any
30 named insured or other person covered thereunder for expenses
31 incurred in connection with any medically necessary benefits provided
32 in-network which represent preventive care as permitted by that
33 federal law.

34 The benefits provided pursuant to this section shall be provided to
35 the same extent as for any other medical condition under the policy,
36 except that a deductible shall not be applied for benefits provided
37 pursuant to this section. This section shall apply to all group health
38 insurance policies in which the health insurer has reserved the right to
39 change the premium.

40

41 9. (New Section) Notwithstanding the provisions of section 3 of
42 P.L.1995, c.316 (C.17B:27-46.11) regarding deductibles for a high
43 deductible health plan, a group health insurance policy providing
44 hospital or medical expense benefits for groups with more than 50
45 persons, that qualifies as a high deductible health plan for which
46 qualified medical expenses are paid using a health savings account

1 established pursuant to section 223 of the federal Internal Revenue
2 Code of 1986 (26 U.S.C. s.223), and that is delivered, issued,
3 executed or renewed in this State, or approved for issuance or renewal
4 in this State by the Commissioner of Banking and Insurance on or after
5 the effective date of P.L. , c. (C.) (pending before the
6 Legislature as this bill), shall not apply a deductible for any benefits for
7 which a deductible is not applicable pursuant to any law enacted after
8 the effective date of P.L. , c. (C.) (pending before the
9 Legislature as this bill).

10 This section shall apply to all group health insurance policies in
11 which the health insurer has reserved the right to change the premium.

12

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

15 4. A certificate of authority to establish and operate a health
16 maintenance organization in this State shall not be issued or continued
17 by the Commissioner of Health and Senior Services on or after the
18 effective date of [this act] P.L. , c. (C.) (pending before the
19 Legislature as this bill) unless the health maintenance organization
20 offers health care services to any enrollee which include:

21 a. 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 b. 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 health
30 maintenance organization shall notify its enrollees, in writing, of any
31 change in the health care services provided with respect to childhood
32 immunizations and any related changes in premium. Such notification
33 shall be in a form and manner to be determined by the Commissioner
34 of Banking and Insurance.

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

42 The health care services provided pursuant to this section shall be
43 provided to the same extent as for any other medical condition under
44 the contract, except that [no] a deductible shall not be applied for
45 services provided pursuant to this section; however, with respect to a
46 contract that qualifies as a high deductible health plan for which

1 qualified medical expenses are paid using a health savings account
2 established pursuant to section 223 of the federal Internal Revenue
3 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for
4 any services provided pursuant to this section that represent preventive
5 care as permitted by that federal law, and shall not be applied as
6 provided pursuant to section 12 of P.L. , c. (C.) (pending
7 before the Legislature as this bill). This section shall apply to all
8 contracts under which the health maintenance organization has
9 reserved the right to change the schedule of charges for enrollee
10 coverage.

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

12

13 11. (New section) A certificate of authority to establish and
14 operate a health maintenance organization, which organization offers
15 a contract that qualifies as a high deductible health plan for which
16 qualified medical expenses are paid using a health savings account
17 established pursuant to section 223 of the federal Internal Revenue
18 Code of 1986 (26 U.S.C. s.223), shall not be issued or continued by
19 the Commissioner of Health and Senior Services on or after the
20 effective date of P.L. , c. (C.) (pending before the Legislature
21 as this bill), unless the health maintenance organization offers health
22 care services to any enrollee which include services provided in-
23 network which represent medically necessary preventive care as
24 permitted by that federal law.

25 The services provided pursuant to this section shall be provided to
26 the same extent as for any other medical condition under the contract,
27 except that a deductible shall not be applied for services provided
28 pursuant to this section. This section shall apply to all contracts under
29 which the health maintenance organization has reserved the right to
30 change the schedule of charges for enrollee coverage.

31

32 12. (New Section) Notwithstanding the provisions of section 4 of
33 P.L.1995, c.316 (C.26:2J-4.10) regarding deductibles for a high
34 deductible health plan, a contract offered by a health maintenance
35 organization, which certificate of authority to establish and operate is
36 issued or continued by the Commissioner of Health and Senior
37 Services on or after the effective date of P.L. , c. (C.)
38 (pending before the Legislature as this bill), that qualifies as a high
39 deductible health plan for which qualified medical expenses are paid
40 using a health savings account established pursuant to section 223 of
41 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not
42 apply a deductible for any benefits in which a deductible is not
43 applicable pursuant to any law enacted after the effective date of
44 P.L. , c. (C.) (pending before the Legislature as this bill).

45 This section shall apply to all contracts under which the health
46 maintenance organization has reserved the right to change the schedule

1 of charges for enrollee coverage.

2

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

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

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

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

31 (1) to an individual who has, under creditable coverage, with no
32 intervening lapse in coverage of more than 31 days, been treated or
33 diagnosed by a physician for a condition under that plan or satisfied a
34 12-month preexisting condition limitation; or

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

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

43 d. After the board's establishment of the individual health benefits
44 plans required pursuant to section 3 of P.L.1992, c.161
45 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier
46 shall file the policy or contract forms with the board and certify to the

1 board that the health benefits plans to be used by the carrier are in
2 substantial compliance with the provisions in the corresponding board
3 approved plans. The certification shall be signed by the chief
4 executive officer of the carrier. Upon receipt by the board of the
5 certification, the certified plans may be used until the board, after
6 notice and hearing, disapproves their continued use.

7 e. Effective immediately for an individual health benefits plan
8 issued on or after the effective date of [P.L.1995, c.316
9 (C.17:48E-35.10 et al.)] P.L. , c. (C.) (pending before the
10 Legislature as this bill) and effective on the first 12-month anniversary
11 date of an individual health benefits plan in effect on the effective date
12 of [P.L.1995, c.316 (C.17:48E-35.10 et al.)] P.L. , c. (C.)
13 (pending before the Legislature as this bill), the individual health
14 benefits plans required pursuant to section 3 of P.L.1992, c.161
15 (C.17B:27A-4), including any plan offered by a federally qualified
16 health maintenance organization, shall contain benefits for expenses
17 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 immunizations as recommended by the Advisory
24 Committee on Immunization Practices of the United States 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 (3) Screening for newborn hearing loss by appropriate
33 electrophysiologic screening measures and periodic monitoring of
34 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
35 (C.26:2-103.1 et al.). Payment for this screening service shall be
36 separate and distinct from payment for routine new baby care in the
37 form of a newborn hearing screening fee as negotiated with the
38 provider and facility.

39 The benefits provided pursuant to this subsection shall be provided
40 to the same extent as for any other medical condition under the health
41 benefits plan, except that [no] a deductible shall not be applied for
42 benefits provided pursuant to this subsection; however, with respect
43 to a health benefits plan that qualifies as a high deductible health plan
44 for which qualified medical expenses are paid using a health savings
45 account established pursuant to section 223 of the federal Internal
46 Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be

1 applied for any benefits provided pursuant to this subsection that
2 represent preventive care as permitted by that federal law, and shall
3 not be applied as provided pursuant to section 14 of P.L. , c.
4 (C.) (pending before the Legislature as this bill). This subsection
5 shall apply to all individual health benefits plans in which the carrier
6 has reserved the right to change the premium.

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

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

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

26 g. Effective immediately for an individual health benefits plan
27 issued on or after the effective date of P.L. , c. (C.) (pending
28 before the Legislature as this bill) and effective on the first 12-month
29 anniversary date of an individual health benefits plan in effect on the
30 effective date of P.L. , c. (C.) (pending before the Legislature
31 as this bill), the health benefits plans required pursuant to section 3 of
32 P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health
33 plans for which qualified medical expenses are paid using a health
34 savings account established pursuant to section 223 of the federal
35 Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan
36 offered by a federally qualified health maintenance organization, shall
37 contain benefits for expenses incurred in connection with any
38 medically necessary benefits provided in-network which represent
39 preventive care as permitted by that federal law.

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

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

1 14. (New Section) Notwithstanding the provisions of subsection
2 e. of section 6 of P.L.1992, c.161 (C.17B:27A-7) regarding
3 deductibles for a high deductible health plan, a health benefits plan
4 offered pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) on or after
5 the effective date of P.L. , c. (C.) (pending before the
6 Legislature as this bill), that qualifies as a high deductible health plan
7 for which qualified medical expenses are paid using a health savings
8 account established pursuant to section 223 of the federal Internal
9 Revenue Code of 1986 (26 U.S.C.s.223), shall not apply a deductible
10 for any benefits for which a deductible is not applicable pursuant to
11 any law enacted after the effective date of P.L. , c. (C.)
12 (pending before the Legislature as this bill). This section shall apply
13 to all individual health benefits plans in which the carrier has reserved
14 the right to change the premium.

15

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

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

33 (1) Basic inpatient and outpatient hospital care;

34 (2) Basic and extended medical-surgical benefits;

35 (3) Diagnostic tests, including X-rays;

36 (4) Maternity benefits, including prenatal and postnatal care; and

37 (5) Preventive medicine, including periodic physical examinations
38 and inoculations.

39 At least three of the forms shall provide for major medical benefits
40 in varying lifetime aggregates, one of which shall provide at least
41 \$1,000,000 in lifetime aggregate benefits. The policy forms provided
42 pursuant to this section shall contain benefits representing
43 progressively greater actuarial values.

44 Notwithstanding the provisions of this subsection to the contrary,
45 the board also may establish additional policy forms by which a small
46 employer carrier, other than a health maintenance organization, may

1 provide indemnity benefits for health maintenance organization
2 enrollees by direct contract with the enrollees' small employer through
3 a dual arrangement with the health maintenance organization. The
4 dual arrangement shall be filed with the commissioner for approval.
5 The additional policy forms shall be consistent with the general
6 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

14 c. The carrier may establish a premium payment plan which
15 provides installment payments and which may contain reasonable
16 provisions to ensure payment security, provided that provisions to
17 ensure payment security are uniformly applied.

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

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

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

43 Notwithstanding the provisions of this section to the contrary, a
44 health maintenance organization which is approved pursuant to
45 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
46 benefits plans formulated by the board and approved by the

1 commissioner which are in accordance with the provisions of that law
2 in lieu of the five plans required pursuant to this section, except that
3 the plans shall provide the same level of benefits as required for a
4 federally qualified health maintenance organization, including any
5 requirements concerning copayments by enrollees.

6 g. A carrier shall not be required to own or control a health
7 maintenance organization or otherwise affiliate with a health
8 maintenance organization in order to comply with the provisions of
9 this section, but the carrier shall be required to offer the five health
10 benefits plans which are formulated by the board and approved by the
11 commissioner, including one plan which contains benefits and cost
12 sharing levels that are equivalent to those required for health
13 maintenance organizations.

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

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

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

37 (2) The benefit riders provided for in paragraph (1) of this
38 subsection shall be subject to the provisions of section 2, subsection
39 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
40 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23,
41 17B:27A-24, 17B:27A-25, and 17B:27A-27).

42 j. (1) Notwithstanding the provisions of P.L.1992, c.162
43 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
44 by or through a carrier, association, or multiple employer arrangement
45 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
46 paragraph (6) of this subsection are met, issued by or through an

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

17 Nothing in this subsection shall be construed to require an
18 association, multiple employer arrangement or out-of-State trust to
19 provide health benefits coverage to small employers that are not
20 contemplated by the organizational documents, bylaws, or other
21 regulations governing the purpose and operation of the association,
22 multiple employer arrangement or out-of-State trust. Notwithstanding
23 the foregoing provision to the contrary, an association, multiple
24 employer arrangement or out-of-State trust that offers health benefits
25 coverage to its members' employees and dependents:

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

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

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

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

40 (3) (a) A carrier, association, multiple employer arrangement or
41 out-of-State trust may withdraw a health benefits plan marketed to
42 small employers that was in effect on December 31, 1993 with the
43 approval of the commissioner. The commissioner shall approve a
44 request to withdraw a plan, consistent with regulations adopted by the
45 commissioner, only on the grounds that retention of the plan would
46 cause an unreasonable financial burden to the issuing carrier, taking

1 into account the rating provisions of section 9 of P.L.1992, c.162
2 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (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

1 out-of-State trust no later than 180 days after the date of enactment
2 of P.L.1995, c.340. A health benefits plan issued by a carrier through
3 an out-of-State trust that is not filed with the commissioner pursuant
4 to this subparagraph, shall not be permitted to be continued or
5 renewed after the 180-day period.

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

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

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

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

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

1 (12) In a case in which a small employer purchased a health
2 benefits 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.)]
16 P.L. , c. (C.) (pending before the Legislature as this bill)
17 and effective on the first 12-month anniversary date of a health
18 benefits plan in effect on the effective date of [P.L.1995, c.316
19 (C.17:48E-35.10 et al.)] P.L. , c. (C.) (pending before the
20 Legislature as this bill), the health benefits plans required pursuant to
21 this section, including any plans offered by a State approved or
22 federally qualified health maintenance organization, shall contain
23 benefits for expenses incurred in the following:

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

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

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

45 The benefits provided pursuant to this subsection shall be provided
46 to the same extent as for any other medical condition under the health

1 benefits plan, except that [no] a deductible shall not be applied for
2 benefits provided pursuant to this subsection ; however, with respect
3 to a small employer health benefits plan that qualifies as a high
4 deductible health plan for which qualified medical expenses are paid
5 using a health savings account established pursuant to section 223 of
6 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a
7 deductible shall not be applied for any benefits that represent
8 preventive care as permitted by that federal law, and shall not be
9 applied as provided pursuant to section 16 of P.L. ,c. (C.)
10 (pending before the Legislature as this bill). This subsection shall
11 apply to all small employer health benefits plans in which the carrier
12 has reserved the right to change the premium.

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

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

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

35 This subsection shall apply to all small employer health benefits
36 plans in which the carrier has reserved the right to change the
37 premium.

38 n. Effective immediately for a health benefits plan issued on or
39 after the effective date of P.L. , c. (C.) (pending before the
40 Legislature as this bill) and effective on the first 12-month anniversary
41 date of a small employer health benefits plan in effect on the effective
42 date of P.L. , c. (C.) (pending before the Legislature as this
43 bill), the health benefits plans required pursuant to this section that
44 qualify as high deductible health plans for which qualified medical
45 expenses are paid using a health savings account established pursuant
46 to section 223 of the federal Internal Revenue Code of 1986 (26

1 U.S.C. s.223), including any plans offered by a State approved or
2 federally qualified health maintenance organization, shall contain
3 benefits for expenses incurred in connection with any medically
4 necessary benefits provided in-network that represent preventive care
5 as permitted by that federal law.

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

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

13

14 16. (New section) Notwithstanding the provisions of subsection
15 k. of section 3 of P.L.1992, c.162 (C.17B:27A-19) regarding
16 deductibles for a high deductible health plan, a health benefits plan
17 offered pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) on or
18 after the effective date of P.L. , c. (C.) (pending before the
19 Legislature as this bill), that qualifies as a high deductible health plan
20 for which qualified medical expenses are paid using a health savings
21 account established pursuant to section 223 of the federal Internal
22 Revenue Code of 1986 (26 U.S.C. s.223), shall not apply a deductible
23 for any benefits for which a deductible is not applicable pursuant to
24 any law enacted after the effective date of P.L. , c. (C.)
25 (pending before the Legislature as this bill). This section shall apply
26 to all small employer health benefits plans in which the carrier has
27 reserved the right to change the premium.

28

29 17. (New section) A small employer carrier, as a condition of
30 transacting business in this State, may offer, on or after the effective
31 date of P.L. , c. (C.) (pending before the Legislature as this
32 bill), a health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-
33 17 et seq.) that qualifies as a high deductible health plan for which
34 qualified medical expenses are paid using a health savings account
35 established pursuant to section 223 of the federal Internal Revenue
36 Code of 1986 (26 U.S.C. s.223), if that health benefits plan is offered
37 to an eligible small employer that:

38 a. is a policy or contract holder prior to and on or after the
39 effective date of P.L. ,c. (C.) (pending before the Legislature
40 as this bill) under a small employer health benefits plan issued pursuant
41 to P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as
42 a high deductible health plan for which qualified medical expenses are
43 paid using a health savings account established pursuant to section 223
44 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223);

45 b. is not a policy or contract holder on or after the effective date
46 of P.L. , c. (C.) (pending before the Legislature as this bill)

1 under a small employer health benefits plan issued pursuant to
2 P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as a
3 high deductible health plan for which qualified medical expenses are
4 paid using a health savings account established pursuant to section 223
5 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) for a
6 period of five years; or

7 c. was not a policy or contract holder under a small employer
8 health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-
9 17 et seq.) prior to the effective date of P.L. , c. (C.)
10 (pending before the Legislature as this bill).

11

12 18. (New section) a. An insurance company, health service
13 corporation, hospital service corporation, medical service corporation
14 or health maintenance organization authorized to issue health benefits
15 plans in this State shall not issue or renew a high deductible health
16 plan for which qualified medical expenses are paid using a health
17 savings account established pursuant to section 223 of the federal
18 Internal Revenue Code of 1986 (26 U.S.C. s.223) on or after the
19 effective date of P.L. , c. (C.) (pending before the Legislature
20 as this bill), unless the application for the contract or policy is
21 accompanied by a written notice, approved by the Commissioner of
22 Banking and Insurance, identifying and containing a one page, double-
23 sided declaration of understanding for high deductible health plans for
24 which qualified medical expenses are paid using a health savings
25 account established pursuant to section 223 of the federal Internal
26 Revenue Code of 1986 (26 U.S.C. s.223). At the time a high
27 deductible health plan for which qualified medical expenses are paid
28 using a health savings account established pursuant to section 223 of
29 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) is issued
30 or renewed, the contract holder or policyholder shall sign and return
31 a copy of the one page, double-sided declaration of understanding to
32 the insurance company, health service corporation, hospital service
33 corporation, medical service corporation or health maintenance
34 organization. The contract holder or policyholder is responsible for
35 retaining a copy of the one page, double-sided declaration of
36 understanding.

37 b. The declaration of understanding shall include a signature line
38 representing the recipient's receipt and understanding of the
39 declaration, and shall also include, but not be limited to, information
40 as to the terms of the plan, presented in plain and simple language,
41 concerning:

42 (1) covered services;

43 (2) applicable deductibles;

44 (3) the responsibility of the contract holder or policyholder and any
45 other covered persons for applicable deductibles;

46 (4) claims processing; and

1 (5) any other information required by State or federal law.

2 c. The Commissioner of Banking and Insurance shall enforce the
3 provisions of this section. An insurance company, health service
4 corporation, hospital service corporation, medical service corporation
5 or health maintenance organization found in violation of this section
6 shall be liable for a civil penalty of not more than \$1,000 for each day
7 that the payer is in violation if reasonable notice in writing is given of
8 the intent to levy the penalty and, at the discretion of the
9 commissioner, the payer has 30 days, or such additional time as the
10 commissioner shall determine to be reasonable, to remedy the
11 condition which gave rise to the violation and fails to do so within the
12 time allowed. The penalty shall be collected by the commissioner in
13 the name of the State in a summary proceeding in accordance with the
14 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
15 seq.).

16 d. Nothing in this section shall be construed to prohibit the
17 promulgation of regulations by the Commissioner of Banking and
18 Insurance to establish standards for the declaration of understanding
19 required pursuant to this section, which standards may require the
20 declaration of understanding to include additional information not
21 stated in this section as deemed appropriate by the commissioner.

22

23 19. (New section) a. Any health insurer, as a condition of
24 transacting business in this State, offering a contract, policy, or plan
25 that qualifies as a high deductible health plan for which qualified
26 medical expenses are paid using a health savings account established
27 pursuant to section 223 of the federal Internal Revenue Code of 1986
28 (26 U.S.C. s.223), shall provide biannual surveys to the Department
29 of Banking and Insurance, based upon information requested and
30 collected from subscribers, insureds, enrollees, and covered persons
31 covered by qualifying high deductible health plans. Each survey shall
32 request, but is not limited to requesting, information concerning: the
33 income levels of the subscribers, insureds, enrollees, or covered
34 persons, covered by qualifying high deductible health plans; the type
35 of contract, policy, or plan which previously provided coverage to
36 those individuals; the amount of out-of-pocket expenses incurred by
37 those individuals; and the percentage of income used by those
38 individuals to pay deductibles.

39 b. All disclosures made pursuant to this section shall be made in
40 accordance with section 2713 of the "Health Insurance Portability and
41 Accountability Act of 1996," Pub.L.104-191 (42 U.S.C. s.300gg-13).

42

43 20. Section 8 of P.L.1968, c.413 (C.30:4D-8) is amended to read
44 as follows:

45 8. The determination of the method of providing payment of claims
46 under this act shall be made by the State Medicaid Commission on

1 recommendation of the commissioner which method may be:

2 a. (1) By contract, except as prohibited by paragraph (2) of this
3 subsection, with insurance companies incorporated and licensed to do
4 business in the State of New Jersey or with nonprofit health service
5 corporations, dental service corporations, hospital service corporations
6 or medical service corporations, incorporated in New Jersey, and
7 authorized to do business pursuant to P.L.1985, c.236 (C.17:48E-1 et
8 seq.), P.L.1968, c.305 (C.17:48C-1 et seq.), P.L.1938, c.366
9 (C.17:48-1 et seq.) or P.L.1940, c.74 (C.17:48A-1 et seq.), to
10 underwrite, but not for profit, on an insured premium approach, that
11 portion of the program covering all cash grant beneficiaries plus all
12 other State certified recipients of medical assistance within the classes
13 set forth in section 3i. of this act, with the exception of those persons
14 who are confined in institutions for tuberculosis and mental care or
15 who are required by medical necessity to be confined on a presumably
16 permanent basis in other medical care institutions by reason of disease
17 or injury, which contract executed pursuant to this subsection shall
18 provide that for those persons included in the program but not covered
19 on an underwritten basis, the same carrier selected under this
20 subsection shall act as fiscal agent for the department, but not for
21 profit, for such medical assistance benefits as may be available, and
22 any carrier selected pursuant to the provisions of this act is hereby
23 expressly authorized and empowered to undertake the performance of
24 the requirements of such contract.

25 (2) The State Medicaid Commission shall not approve any
26 contract, pursuant to section 11 of P.L.1968, c.413 (C.30:4D-11),
27 with an insurance company or corporation as set forth in paragraph (1)
28 of this subsection that offers to pay all or part of the medical cost of
29 injury, disease or disability of an applicant for or recipient of medical
30 assistance payable under Medicaid using any contract that provides for
31 a deductible which qualifies the contract as a high deductible health
32 plan for which qualified medical expenses are paid using a health
33 savings account established pursuant to section 223 of the federal
34 Internal Revenue Code of 1986 (26 U.S.C. s.223).

35 b. (1) By contract, except as prohibited by paragraph (2) of this
36 subsection, with any corporation doing business in the State of New
37 Jersey, including nonprofit organizations incorporated in New Jersey
38 and authorized to do business pursuant to P.L.1985, c.236
39 (C.17:48E-1 et seq.), P.L.1968, c.305 (C.17:48C-1 et seq.), P.L.1938,
40 c.366 (C. 7:48-1 et seq.) or P.L.1940, c.74 (C.17:48A-1 et seq.), to
41 act as fiscal agent.

42 (2) The State Medicaid Commission shall not direct that payment
43 of claims be made by the Department of Human Services, pursuant to
44 section 11 of P.L.1968, c.413 (C.30:4D-11), with a corporation or
45 nonprofit organization as set forth in paragraph (1) of this subsection
46 that offers to pay all or part of the medical cost of injury, disease or

1 disability of an applicant for or recipient of medical assistance payable
2 under Medicaid using any contract that provides for a deductible
3 which qualifies the contract as a high deductible health plan for which
4 qualified medical expenses are paid using a health savings account
5 established pursuant to section 223 of the federal Internal Revenue
6 Code of 1986 (26 U.S.C. s.223).

7 c. By direct administration by the Department of Human Services.
8 (cf: P.L.1988, c.6, s.2)

9
10 21. (New Section). The Commissioner of Human Services shall
11 not utilize or establish any contract that provides for a deductible
12 which qualifies the contract as a high deductible health plan for which
13 qualified medical expenses are paid using a health savings account
14 established pursuant to section 223 of the federal Internal Revenue
15 Code of 1986 (26 U.S.C. s.223) in the implementation and operation
16 of the NJ FamilyCare Program, established pursuant to sections 3
17 through 5 of P.L.2005, c.156 (C.30:4J-10 through C.30:4J-12).

18
19 22. (New section) a. Notwithstanding the purposes of the "Lead
20 Hazard Control Assistance Fund" provided by P.L.2003, c.311
21 (C.52:27D-437.1 et al.), the Commissioner of Community Affairs shall
22 transfer to the Division of Medical Assistance and Health Services in
23 the Department of Human Services from the "Lead Hazard Control
24 Assistance Fund" established pursuant to section 4 of P.L.2003, c.311
25 (C.52:27D-437.4), upon certification by the director of the division
26 pursuant to paragraph (2) of subsection d. of this section, an amount
27 not to exceed \$500,000 annually in each fiscal year following the
28 effective date of P.L. , c. (C.) (pending before the
29 Legislature as this bill), to fund the costs incurred by licensed health
30 care facilities and licensed health care providers for any necessary
31 medical follow-up and treatment for lead poisoned children covered
32 under a contract, policy, or plan that qualifies as a high deductible
33 health plan for which qualified medical expenses are paid using a
34 health savings account established pursuant to section 223 of the
35 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), as provided
36 in this section.

37 b. The division shall administer a claim reimbursement program to
38 reimburse licensed health care facilities and licensed health care
39 providers for their costs incurred in providing services pursuant to
40 subsection c. of this section for any necessary medical follow-up and
41 treatment of lead poisoned children: (1) whose family income does not
42 exceed 400% of the federal poverty level; (2) who are eligible to
43 receive benefits under a contract, policy, or plan that qualifies as a
44 high deductible health plan for which qualified medical expenses are
45 paid using a health savings account established pursuant to section 223
46 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223); and

1 (3) for whom the deductible limits of that contract, policy, or plan
2 have not been exceeded.

3 c. Licensed health care facilities and licensed health care providers
4 shall provide necessary medical follow-up and treatment of lead
5 poisoned children:(1) whose family income does not exceed 400% of
6 the federal poverty level; (2) who are covered under a contract, policy,
7 or plan that qualifies as a high deductible health plan for which
8 qualified medical expenses are paid using a health savings account
9 established pursuant to section 223 of the federal Internal Revenue
10 Code of 1986 (26 U.S.C. s.223); and (3) for whom the deductible
11 limits of that contract, policy, or plan are not exceeded. Licensed
12 health care facilities and licensed health care providers shall not seek
13 reimbursement for any costs incurred pursuant to this subsection from
14 the insureds covered under a contract, policy, or plan that qualifies as
15 a high deductible health plan for which medical expenses are paid
16 using a health savings account established pursuant to section 223 of
17 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) or the
18 carrier that issued the high deductible health plan for which medical
19 expenses are paid using a health savings account established pursuant
20 to section 223 of the federal Internal Revenue Code of 1986 (26
21 U.S.C. s.223).

22 d. (1) Licensed health care facilities and licensed health care
23 providers shall submit claims for necessary medical follow-up and
24 treatment cost reimbursement to the division in a form and manner as
25 prescribed by the director by regulation.

26 (2) The director of the division shall, at least once every other
27 month, or more frequently as provided by regulation, certify the
28 amount of reimbursement claims submitted by licensed health care
29 facilities and licensed health care providers and forward the
30 certification to the Commissioner of Community Affairs. The
31 commissioner shall, upon receipt of the certification, immediately
32 transfer the specified amount of funds, not to exceed \$500,000
33 annually, from the "Lead Hazard Control Assistance Fund" established
34 pursuant to section 4 of P.L.2003, c.311 (C.52:27D-437.4) to the
35 division.

36 (3) Upon receipt of the funds, the division shall provide
37 reimbursements for services provided pursuant to subsection c. of this
38 section to the licensed health care facilities and licensed health care
39 providers at the Medicaid rate.

40

41 23. (New section) a. The Commissioner of Banking and Insurance
42 shall monitor the implementation and effect of P.L. , c. (C.)
43 (pending before the Legislature as this bill) on the health insurance
44 marketplace and shall report to the Governor, the Legislature, and the
45 committees as provided in subsection c. of this section, no later than:
46 12 months after the effective date of this act with an initial report; and

1 24 months after the effective date of this act with a final report
2 containing the commissioner's findings.

3 b. The commissioner's initial and final reports may include, but
4 shall not be limited to, information concerning: the number of
5 insurance carriers offering only contracts, policies or plans that qualify
6 as high deductible health plans for which qualified medical expenses
7 are paid using a health savings account established pursuant to section
8 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223);
9 the deductible amounts applicable to those plans; any adverse selection
10 by subscribers, insureds, enrollees, or covered persons relative to
11 those plans; any increase in cost shifting to the subscribers, insureds,
12 enrollees, or covered persons covered by those plans; any increase in
13 cost shifting to publicly funded health programs for expenses incurred
14 in treating subscribers, insureds, enrollees, or covered persons covered
15 by those plans; and the data contained in the biannual surveys provided
16 by insurance carriers to the Department of Banking and Insurance as
17 required by section 19 of this act. The final report shall also include
18 the commissioner's recommendation for any legislative reforms
19 deemed appropriate by the commissioner.

20 c. The Senate Health, Human Services and Senior Citizens
21 Committee and the General Assembly Health and Human Services
22 Committee, or their respective successors, are each charged with
23 monitoring and evaluating the effect of the provisions of P.L. ,
24 c. (C.) (pending before the Legislature as this bill) on the
25 insurance marketplace. The Commissioner of Banking and Insurance
26 shall, no later than 24 months after the effective date of P.L. , c.
27 (C.) (pending before the Legislature as this bill), present the
28 findings of the commissioner's final report prepared pursuant to
29 subsection a. of this section before each committee, which committee
30 meetings shall be open to the public and include public comment
31 periods. The committees shall, upon receiving the final report
32 prepared pursuant to subsection a. of this section, and the testimony
33 of the commissioner and the public provided pursuant to this
34 subsection, issue as it may deem necessary and proper,
35 recommendations for administrative or legislative changes affecting the
36 implementation of P.L. , c. (C.) (pending before the
37 Legislature as this bill).

38

39 24. This act shall take effect on December 31, 2005 and shall apply
40 to all contracts and policies that are delivered, issued, executed or
41 renewed or approved for issuance or renewal in this State on or after
42 the effective date.

STATEMENT

1

2

3 This bill facilitates the establishment of health savings accounts in
4 this State. The federal "Medicare Prescription Drug, Improvement
5 and Modernization Act of 2003," Pub. L. 108-173, allows eligible
6 individuals who are enrolled in a qualified high deductible health plan
7 to establish health savings accounts (HSA's) beginning January 1,
8 2004. Contributions to HSA's receive favorable tax treatment in that
9 they may be accumulated over the years, or distributed on a tax-free
10 basis, to pay or reimburse qualifying medical expenses.

11 However, because of the requirements of the federal law, current
12 provisions of existing State law, which require that certain non-
13 preventive care or treatment under health insurance contracts and
14 policies be provided without the application of a deductible, must be
15 modified in order that HSA's may be continuously offered in this State
16 after December 31, 2005. The federal law provided states with a two-
17 year transition period, ending December 31, 2005, in order to
18 accomplish any necessary modifications in State law to allow for the
19 establishment and continuation of HSA's.

20 Therefore, to comply with federal law, the bill prohibits the
21 application of a deductible for any "medically necessary" benefit
22 provided in-network that has been deemed under the applicable federal
23 law to represent preventive care, if the benefit is provided under a high
24 deductible health plan linked to an HSA. However, notwithstanding
25 this provision and absent any subsequent legislative reforms to the
26 contrary, the bill prohibits the application of a deductible for any
27 benefit if, after the effective date of the bill, the Legislature enacts a
28 law that prohibits the application of a deductible to any benefit,
29 whether or not "medically necessary," preventive, or provided in-
30 network, covered under any health insurance policy.

31 The provisions of the bill allow a deductible to apply to necessary
32 medical follow-up and treatment for lead poisoned children covered
33 under a high deductible health plan linked to an HSA. Under current
34 law, these services are exempted from incurring a deductible.
35 However, so as to not thwart the availability of treatment of lead
36 poisoned children for families who cannot afford a deductible payment,
37 the bill requires that health care facilities and providers provide all
38 necessary medical follow-up and treatment of lead poisoned children:
39 (1) whose family income does not exceed 400% of the federal poverty
40 level; (2) who are eligible to receive benefits under a high deductible
41 health plan for which qualified expenses are paid using a health savings
42 account; and (3) for whom the deductible limits of that plan have not
43 yet been exceeded. The facilities and providers shall not seek
44 reimbursement for the delivery of qualified services from either the
45 insured or under the high deductible health plan.

46 Health care facilities and providers that incur expenses pursuant to
47 these provisions may submit a claim to a claim reimbursement program

1 managed by the Division of Medical Assistance and Health Services in
2 the Department of Human Services. Facilities and providers shall be
3 reimbursed at the Medicaid rate. To fund the reimbursement program,
4 an amount not to exceed \$500,000 each fiscal year shall be transferred
5 from the "Lead Hazard Control Assistance Fund," established pursuant
6 to section 4 of P.L.2003, c.311 (C.52:27D-437.4).

7 The bill also prohibits the use of high deductible health plans with
8 respect to the administration of Medicaid in this State and the NJ
9 FamilyCare Program.

10 All health insurance carriers offering high deductible health plans
11 are required to provide a written notice, approved by the
12 Commissioner of Banking and Insurance, with any application for a
13 high deductible health plan contract or policy. The notice, known as
14 a declaration of understanding, shall include a signature line
15 representing the recipient's receipt and understanding of the
16 declaration, and include information as to the terms of the high
17 deductible health plan, such as covered services, applicable
18 deductibles, and claims processing. The commissioner shall enforce
19 this notice requirement, which if violated carries a civil penalty of not
20 more than \$1,000 for each day that the carrier is in violation of the
21 applicable bill provisions.

22 All health insurance carriers offering high deductible health plans
23 are also required to provide the Department of Banking and Insurance
24 with biannual surveys, based upon information requested and collected
25 from subscribers, insureds, enrollees, and covered persons of such
26 plans. These surveys are intended to gather information concerning
27 the impact of high deductible health plans on those individuals covered
28 by such plans.

29 With respect to small employer carriers, the bill permits such
30 carriers to offer high deductible health plans only to small employers
31 that: 1) currently offer health benefits plans other than a high
32 deductible health plan; 2) previously offered health benefits plans other
33 than a high deductible health plan, but have not offered any such plan
34 for a period of five years; or 3) never before offered any type of health
35 benefits plan.

36 Finally, the bill provides that the Commissioner of Banking and
37 Insurance shall monitor the implementation of the bill and report to the
38 Governor and certain members of the Legislature information
39 concerning the prevalence of high deductible health plans in the
40 marketplace, and any effect on the insurance coverage rates in the
41 State or enrollment rates in State-funded medical assistance programs.

42

43

44

45 Concerns availability, deductibles, and certain treatment under high
46 deductible health plans paid through federally qualified health savings
47 accounts.

ASSEMBLY, No. 4543

STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED DECEMBER 12, 2005

Sponsored by:

Assemblyman NEIL M. COHEN

District 20 (Union)

Assemblyman DAVID C. RUSSO

District 40 (Bergen, Essex and Passaic)

Co-Sponsored by:

Assemblymen Prieto, Conners, Panter, Assemblywoman Cruz-Perez, Assemblymen Diegnan, Azzolina, Baroni, Bateman, Biondi, Blee, Bodine, Bramnick, Carroll, Chatzidakis, Connors, Conover, Corodemus, Dancer, DeCroce, DiGaetano, Doherty, Gregg, Holzapfel, S.Kean, Malone, Assemblywoman McHose, Assemblymen Merkt, Munoz, Assemblywoman Myers, Assemblymen O'Toole, Pennacchio, Rooney, Rumpf, Thompson, Assemblywoman Vandervalk, Assemblyman Wolfe, Senators Rice, T.Kean, Bucco and Littell

SYNOPSIS

Concerns availability, deductibles, and certain treatment under high deductible health plans paid through federally qualified health savings accounts.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 12/16/2005)

1 AN ACT concerning certain high deductible health plans and amending
2 and supplementing various parts of the statutory law.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
8 read as follows:

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

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

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

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

38 The benefits provided pursuant to this section shall be provided to
39 the same extent as for any other medical condition under the contract,
40 except that **[no]** a deductible shall not be applied for benefits provided
41 pursuant to this section; however, with respect to a contract that
42 qualifies as a high deductible health plan for which qualified medical
43 expenses are paid using a health savings account established pursuant

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

Matter underlined thus is new matter.

1 to section 223 of the federal Internal Revenue Code of 1986 (26
2 U.S.C. s.223), a deductible shall not be applied for any benefits
3 provided pursuant to this section which represent preventive care as
4 permitted by that federal law, and shall not be applied as provided
5 pursuant to section 3 of P.L. , c. (C.) (pending before the
6 Legislature as this bill) . This section shall apply to all health service
7 corporation contracts in which the health service corporation has
8 reserved the right to change the premium.
9 (cf: P.L.2001, c.373, s.10)

10
11 2. (New section) No health service corporation contract providing
12 hospital or medical expense benefits for groups with greater than 50
13 persons, that qualifies as a high deductible health plan for which
14 qualified medical expenses are paid using a health savings account
15 established pursuant to section 223 of the federal Internal Revenue
16 Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed
17 or renewed in this State, or approved for issuance or renewal in this
18 State by the Commissioner of Banking and Insurance on or after the
19 effective date of P.L. , c. (C.) (pending before the
20 Legislature as this bill), unless the contract provides benefits to any
21 named subscriber or other person covered thereunder for expenses
22 incurred in connection with any medically necessary benefits provided
23 in-network that represent preventive care as permitted by that federal
24 law.

25 The benefits provided pursuant to this section shall be provided to
26 the same extent as for any other medical condition under the contract,
27 except that a deductible shall not be applied for benefits provided
28 pursuant to this section. This section shall apply to all health service
29 corporation contracts in which the health service corporation has
30 reserved the right to change the premium.

31
32 3. (New Section) Notwithstanding the provisions of section 1 of
33 P.L.1995, c.316 (C.17:48E-35.10) regarding deductibles for a high
34 deductible health plan, a contract offered by a health service
35 corporation providing hospital or medical expense benefits for groups
36 with greater than 50 persons, that qualifies as a high deductible health
37 plan for which qualified medical expenses are paid using a health
38 savings account established pursuant to section 223 of the federal
39 Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is
40 delivered, issued, executed or renewed in this State, or approved for
41 issuance or renewal in this State by the Commissioner of Banking and
42 Insurance on or after the effective date of P.L. , c. (C.)
43 (pending before the Legislature as this bill), shall not apply a
44 deductible for any benefits for which a deductible is not applicable
45 pursuant to any law enacted after the effective date of P.L. , c.
46 (C.) (pending before the Legislature as this bill).

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

4
5 4. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
6 as follows:

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

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

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

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

36 The benefits provided pursuant to this section shall be provided to
37 the same extent as for any other medical condition under the contract,
38 except that [no] a deductible shall not be applied for benefits provided
39 pursuant to this section; however, with respect to a contract that
40 qualifies as a high deductible health plan for which qualified medical
41 expenses are paid using a health savings account established pursuant
42 to section 223 of the federal Internal Revenue Code of 1986 (26
43 U.S.C. s.223), a deductible shall not be applied for any benefits
44 provided pursuant to this section which represent preventive care as
45 permitted by that federal law, and shall not be applied as provided
46 pursuant to section 6 of P.L.____, c.____ (C.____) (pending before

1 the Legislature as this bill). This section shall apply to all hospital
2 service corporation contracts in which the health service corporation
3 has reserved the right to change the premium.
4 (cf: P.L.2001, c.373, s.11)

5
6 5. (New section) No hospital service corporation contract
7 providing hospital or medical expense benefits for groups with greater
8 than 50 persons, that qualifies as a high deductible health plan for
9 which qualified medical expenses are paid using a health savings
10 account established pursuant to section 223 of the federal Internal
11 Revenue Code of 1986 (26 U.S.C. s.223), shall be delivered, issued,
12 executed or renewed in this State, or approved for issuance or renewal
13 in this State by the Commissioner of Banking and Insurance on or after
14 the effective date of P.L. , c. (C.) (pending before the
15 Legislature as this bill), unless the contract provides benefits to any
16 named subscriber or other person covered thereunder for expenses
17 incurred in connection with any medically necessary benefits provided
18 in-network that represent preventive care as permitted by that federal
19 law.

20 The benefits provided pursuant to this section shall be provided to
21 the same extent as for any other medical condition under the contract,
22 except that a deductible shall not be applied for benefits provided
23 pursuant to this section. This section shall apply to all hospital service
24 corporation contracts in which the hospital service corporation has
25 reserved the right to change the premium.

26
27 6. (New section) Notwithstanding the provisions of section 2 of
28 P.L.1995, c.316 (C.17:48-6m) regarding deductibles for a high
29 deductible health plan, a contract offered by a hospital service
30 corporation providing hospital or medical expense benefits for groups
31 with greater than 50 persons, that qualifies as a high deductible health
32 plan for which qualified medical expenses are paid using a health
33 savings account established pursuant to section 223 of the federal
34 Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is
35 delivered, issued, executed or renewed in this State, or approved for
36 issuance or renewal in this State by the Commissioner of Banking and
37 Insurance on or after the effective date of P.L. , c. (C.)
38 (pending before the Legislature as this bill), shall not apply a
39 deductible for any benefits for which a deductible is not applicable
40 pursuant to any law enacted after the effective date of P.L. , c.
41 (C.) (pending before the Legislature as this bill).

42 This section shall apply to all hospital service corporation contracts
43 in which the hospital service corporation has reserved the right to
44 change the premium.

45
46 7. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) is amended to

1 read as follows:

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

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

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

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

30 The benefits provided pursuant to this section shall be provided to
31 the same extent as for any other medical condition under the policy,
32 except that [no] a deductible shall not be applied for benefits provided
33 pursuant to this section; however, with respect to a policy that
34 qualifies as a high deductible health plan for which qualified medical
35 expenses are paid using a health savings account established pursuant
36 to section 223 of the federal Internal Revenue Code of 1986 (26
37 U.S.C. s.223), a deductible shall not be applied for any benefits
38 provided pursuant to this section that represent preventive care as
39 permitted by that federal law, and shall not be applied as provided
40 pursuant to section 9 of P.L.____, c.____ (C.____) (pending before the
41 Legislature as this bill). This section shall apply to all group health
42 insurance policies in which the health insurer has reserved the right to
43 change the premium.

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

45

46 8. (New section) No group health insurance policy providing

1 hospital or medical expense benefits for groups with more than 50
2 persons, that qualifies as a high deductible health plan for which
3 qualified medical expenses are paid using a health savings account
4 established pursuant to section 223 of the federal Internal Revenue
5 Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed
6 or renewed in this State, or approved for issuance or renewal in this
7 State by the Commissioner of Banking and Insurance on or after the
8 effective date of P.L. , c. (C.) (pending before the
9 Legislature as this bill), unless the policy provides benefits to any
10 named insured or other person covered thereunder for expenses
11 incurred in connection with any medically necessary benefits provided
12 in-network which represent preventive care as permitted by that
13 federal law.

14 The benefits provided pursuant to this section shall be provided to
15 the same extent as for any other medical condition under the policy,
16 except that a deductible shall not be applied for benefits provided
17 pursuant to this section. This section shall apply to all group health
18 insurance policies in which the health insurer has reserved the right to
19 change the premium.

20

21 9. (New Section) Notwithstanding the provisions of section 3 of
22 P.L.1995, c.316 (C.17B:27-46.11) regarding deductibles for a high
23 deductible health plan, a group health insurance policy providing
24 hospital or medical expense benefits for groups with more than 50
25 persons, that qualifies as a high deductible health plan for which
26 qualified medical expenses are paid using a health savings account
27 established pursuant to section 223 of the federal Internal Revenue
28 Code of 1986 (26 U.S.C. s.223), and that is delivered, issued,
29 executed or renewed in this State, or approved for issuance or renewal
30 in this State by the Commissioner of Banking and Insurance on or after
31 the effective date of P.L. , c. (C.) (pending before the
32 Legislature as this bill), shall not apply a deductible for any benefits for
33 which a deductible is not applicable pursuant to any law enacted after
34 the effective date of P.L. , c. (C.) (pending before the
35 Legislature as this bill).

36 This section shall apply to all group health insurance policies in
37 which the health insurer has reserved the right to change the premium.

38

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

41 4. A certificate of authority to establish and operate a health
42 maintenance organization in this State shall not be issued or continued
43 by the Commissioner of Health and Senior Services on or after the
44 effective date of [this act] P.L. , c. (C.) (pending before the
45 Legislature as this bill) unless the health maintenance organization
46 offers health care services to any enrollee which include:

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

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

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

22 The health care services provided pursuant to this section shall be
23 provided to the same extent as for any other medical condition under
24 the contract, except that [no] a deductible shall not be applied for
25 services provided pursuant to this section; however, with respect to a
26 contract that qualifies as a high deductible health plan for which
27 qualified medical expenses are paid using a health savings account
28 established pursuant to section 223 of the federal Internal Revenue
29 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for
30 any services provided pursuant to this section that represent preventive
31 care as permitted by that federal law, and shall not be applied as
32 provided pursuant to section 12 of P.L. , c. (C.) (pending
33 before the Legislature as this bill). This section shall apply to all
34 contracts under which the health maintenance organization has
35 reserved the right to change the schedule of charges for enrollee
36 coverage.
37 (cf: P.L.2001, c.373, s.13).

38
39 11. (New section) A certificate of authority to establish and
40 operate a health maintenance organization, which organization offers
41 a contract that qualifies as a high deductible health plan for which
42 qualified medical expenses are paid using a health savings account
43 established pursuant to section 223 of the federal Internal Revenue
44 Code of 1986 (26 U.S.C. s.223), shall not be issued or continued by
45 the Commissioner of Health and Senior Services on or after the
46 effective date of P.L. , c. (C.) (pending before the Legislature

1 as this bill), unless the health maintenance organization offers health
2 care services to any enrollee which include services provided in-
3 network which represent medically necessary preventive care as
4 permitted by that federal law.

5 The services provided pursuant to this section shall be provided to
6 the same extent as for any other medical condition under the contract,
7 except that a deductible shall not be applied for services provided
8 pursuant to this section. This section shall apply to all contracts under
9 which the health maintenance organization has reserved the right to
10 change the schedule of charges for enrollee coverage.

11
12 12. (New Section) Notwithstanding the provisions of section 4 of
13 P.L.1995, c.316 (C.26:2J-4.10) regarding deductibles for a high
14 deductible health plan, a contract offered by a health maintenance
15 organization, which certificate of authority to establish and operate is
16 issued or continued by the Commissioner of Health and Senior
17 Services on or after the effective date of P.L. , c. (C.)
18 (pending before the Legislature as this bill), that qualifies as a high
19 deductible health plan for which qualified medical expenses are paid
20 using a health savings account established pursuant to section 223 of
21 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not
22 apply a deductible for any benefits in which a deductible is not
23 applicable pursuant to any law enacted after the effective date of
24 P.L. , c. (C.) (pending before the Legislature as this bill).

25 This section shall apply to all contracts under which the health
26 maintenance organization has reserved the right to change the schedule
27 of charges for enrollee coverage.

28
29 13. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
30 read as follows:

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

43 a. The individual health benefits plans established by the board may
44 include cost containment measures such as, but not limited to:
45 utilization review of health care services, including review of medical
46 necessity of hospital and physician services; case management benefit

1 alternatives; selective contracting with hospitals, physicians, and other
2 health care providers; and reasonable benefit differentials applicable to
3 participating and nonparticipating providers; and other managed care
4 provisions.

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

11 (1) to an individual who has, under creditable coverage, with no
12 intervening lapse in coverage of more than 31 days, been treated or
13 diagnosed by a physician for a condition under that plan or satisfied a
14 12-month preexisting condition limitation; or

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

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

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

33 e. Effective immediately for an individual health benefits plan
34 issued on or after the effective date of [P.L.1995, c.316
35 (C.17:48E-35.10 et al.)] P.L. _____, c. _____ (pending before the
36 Legislature as this bill) and effective on the first 12-month anniversary
37 date of an individual health benefits plan in effect on the effective date
38 of [P.L.1995, c.316 (C.17:48E-35.10 et al.)] P.L. _____, c. _____
39 (pending before the Legislature as this bill), the individual health
40 benefits plans required pursuant to section 3 of P.L.1992, c.161
41 (C.17B:27A-4), including any plan offered by a federally qualified
42 health maintenance organization, shall contain benefits for expenses
43 incurred in the following:

44 (1) Screening by blood lead measurement for lead poisoning for
45 children, including confirmatory blood lead testing as specified by the
46 Department of Health and Senior Services pursuant to section 7 of

1 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
2 necessary medical follow-up and treatment for lead poisoned children.

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

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

19 The benefits provided pursuant to this subsection shall be provided
20 to the same extent as for any other medical condition under the health
21 benefits plan, except that [no] a deductible shall not be applied for
22 benefits provided pursuant to this subsection; however, with respect
23 to a health benefits plan that qualifies as a high deductible health plan
24 for which qualified medical expenses are paid using a health savings
25 account established pursuant to section 223 of the federal Internal
26 Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be
27 applied for any benefits provided pursuant to this subsection that
28 represent preventive care as permitted by that federal law, and shall
29 not be applied as provided pursuant to section 14 of P.L. , c.
30 (C.) (pending before the Legislature as this bill). This subsection
31 shall apply to all individual health benefits plans in which the carrier
32 has reserved the right to change the premium.

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

1 necessity of the specialized infant formula.

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

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

6 g. Effective immediately for an individual health benefits plan
7 issued on or after the effective date of P.L. , c. (C.) (pending
8 before the Legislature as this bill) and effective on the first 12-month
9 anniversary date of an individual health benefits plan in effect on the
10 effective date of P.L. , c. (C.) (pending before the Legislature
11 as this bill), the health benefits plans required pursuant to section 3 of
12 P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health
13 plans for which qualified medical expenses are paid using a health
14 savings account established pursuant to section 223 of the federal
15 Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan
16 offered by a federally qualified health maintenance organization, shall
17 contain benefits for expenses incurred in connection with any
18 medically necessary benefits provided in-network which represent
19 preventive care as permitted by that federal law.

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

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

27

28 14. (New Section) Notwithstanding the provisions of subsection
29 e. of section 6 of P.L.1992, c.161 (C.17B:27A-7) regarding
30 deductibles for a high deductible health plan, a health benefits plan
31 offered pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) on or after
32 the effective date of P.L. , c. (C.) (pending before the
33 Legislature as this bill), that qualifies as a high deductible health plan
34 for which qualified medical expenses are paid using a health savings
35 account established pursuant to section 223 of the federal Internal
36 Revenue Code of 1986 (26 U.S.C.s.223), shall not apply a deductible
37 for any benefits for which a deductible is not applicable pursuant to
38 any law enacted after the effective date of P.L. , c. (C.)
39 (pending before the Legislature as this bill). This section shall apply
40 to all individual health benefits plans in which the carrier has reserved
41 the right to change the premium.

42

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

45 3. a. Except as provided in subsection f. of this section, every
46 small employer carrier shall, as a condition of transacting business in

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

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

20 At least three of the forms shall provide for major medical benefits
21 in varying lifetime aggregates, one of which shall provide at least
22 \$1,000,000 in lifetime aggregate benefits. The policy forms provided
23 pursuant to this section shall contain benefits representing
24 progressively greater actuarial values.

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

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

41 c. The carrier may establish a premium payment plan which
42 provides installment payments and which may contain reasonable
43 provisions to ensure payment security, provided that provisions to
44 ensure payment security are uniformly applied.

45 d. In addition to the five standard policies described in subsection
46 a. of this section, the board may develop up to five rider packages.

1 Any such package which a carrier chooses to offer shall be issued to
2 a small employer who pays the premium therefor, and shall be subject
3 to the rating methodology set forth in section 9 of P.L.1992, c.162
4 (C.17B:27A-25).

5 e. Notwithstanding the provisions of subsection a. of this section
6 to the contrary, the board may approve a health benefits plan
7 containing only medical-surgical benefits or major medical expense
8 benefits, or a combination thereof, which is issued as a separate policy
9 in conjunction with a contract of insurance for hospital expense
10 benefits issued by a hospital service corporation, if the health benefits
11 plan and hospital service corporation contract combined otherwise
12 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et
13 seq.). Deductibles and coinsurance limits for the contract combined
14 may be allocated between the separate contracts at the discretion of
15 the carrier and the hospital service corporation.

16 f. Notwithstanding the provisions of this section to the contrary,
17 a health maintenance organization which is a qualified health
18 maintenance organization pursuant to the "Health Maintenance
19 Organization Act of 1973," Pub.L.93-222 (42 U.S.C.s.300e et seq.)
20 shall be permitted to offer health benefits plans formulated by the
21 board and approved by the commissioner which are in accordance with
22 the provisions of that law in lieu of the five plans required pursuant to
23 this section.

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

33 g. A carrier shall not be required to own or control a health
34 maintenance organization or otherwise affiliate with a health
35 maintenance organization in order to comply with the provisions of
36 this section, but the carrier shall be required to offer the five health
37 benefits plans which are formulated by the board and approved by the
38 commissioner, including one plan which contains benefits and cost
39 sharing levels that are equivalent to those required for health
40 maintenance organizations.

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

45 i. (1) In addition to the rider packages provided for in subsection
46 d. of this section, every carrier may offer, in connection with the five

1 health benefits plans required to be offered by this section, any number
2 of riders which may revise the coverage offered by the five plans in
3 any way, provided, however, that any form of such rider or
4 amendment thereof which decreases benefits or decreases the actuarial
5 value of one of the five plans shall be filed for informational purposes
6 with the board and for approval by the commissioner before such rider
7 may be sold. Any rider or amendment thereof which adds benefits or
8 increases the actuarial value of one of the five plans shall be filed with
9 the board for informational purposes before such rider may be sold.

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

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

23 j. (1) Notwithstanding the provisions of P.L.1992, c.162
24 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
25 by or through a carrier, association, or multiple employer arrangement
26 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
27 paragraph (6) of this subsection are met, issued by or through an
28 out-of-State trust prior to January 1, 1994, at the option of a small
29 employer policy or contract holder, may be renewed or continued after
30 February 28, 1994, or in the case of such a health benefits plan whose
31 anniversary date occurred between March 1, 1994 and the effective
32 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
33 within 60 days of that anniversary date and renewed or continued if,
34 beginning on the first 12-month anniversary date occurring on or after
35 the sixtieth day after the board adopts regulations concerning the
36 implementation of the rating factors permitted by section 9 of
37 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
38 delivery of the health benefits plan, the health benefits plan renewed,
39 continued or reinstated pursuant to this subsection complies with the
40 provisions of section 2, subsection b. of section 3, and sections 6, 7,
41 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19,
42 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
43 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

44 Nothing in this subsection shall be construed to require an
45 association, multiple employer arrangement or out-of-State trust to
46 provide health benefits coverage to small employers that are not

1 contemplated by the organizational documents, bylaws, or other
2 regulations governing the purpose and operation of the association,
3 multiple employer arrangement or out-of-State trust. Notwithstanding
4 the foregoing provision to the contrary, an association, multiple
5 employer arrangement or out-of-State trust that offers health benefits
6 coverage to its members' employees and dependents:

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

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

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

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

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

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

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

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

41 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
42 of this paragraph, a health benefits plan renewed, continued or
43 reinstated pursuant to this subsection shall be filed with the
44 commissioner for informational purposes within 30 days after its
45 renewal date. No later than 60 days after the board adopts regulations
46 concerning the implementation of the rating factors permitted by

1 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
2 amended to show any modifications in the plan that are necessary to
3 comply with the provisions of this subsection. The commissioner shall
4 monitor compliance of any such plan with the requirements of this
5 subsection, except that the board shall enforce the loss ratio
6 requirements.

7 (b) A health benefits plan filed with the commissioner pursuant to
8 subparagraph (a) of this paragraph may be amended as to its benefit
9 structure if the amendment does not reduce the actuarial value and
10 benefits coverage of the health benefits plan below that of the lowest
11 standard health benefits plan established by the board pursuant to
12 subsection a. of this section. The amendment shall be filed with the
13 commissioner for approval pursuant to the terms of sections 4, 8, 12
14 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
15 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
16 shall comply with the provisions of sections 2 and 9 of P.L.1992,
17 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
18 c.340 (C.17B:27A-19.3).

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

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

41 (8) Notwithstanding the provisions of P.L.1992, c.162
42 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
43 employer arrangement or out-of-State trust may offer coverage under
44 a health benefits plan authorized to be renewed, continued or
45 reinstated pursuant to this subsection to new employees of small
46 employer groups covered by the health benefits plan in accordance

1 with the provisions of paragraph (1) of this subsection.

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

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

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

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

35 Notwithstanding the provisions of subparagraph (b) of paragraph
36 (6) of this subsection to the contrary, a small employer who changes
37 its health benefits plan's issuing carrier pursuant to the provisions of
38 this paragraph, shall not, upon changing carriers, modify the benefit
39 structure of that health benefits plan within six months of the date the
40 issuing carrier was changed.

41 k. Effective immediately for a health benefits plan issued on or
42 after the effective date of [P.L.1995, c.316 (C.17:48E-35.10 et al.)]
43 P.L. , c. (C.) (pending before the Legislature as this bill)
44 and effective on the first 12-month anniversary date of a health
45 benefits plan in effect on the effective date of [P.L.1995, c.316
46 (C.17:48E-35.10 et al.)] P.L. , c. (C.) (pending before the

1 Legislature as this bill), the health benefits plans required pursuant to
2 this section, including any plans offered by a State approved or
3 federally qualified health maintenance organization, shall contain
4 benefits for expenses incurred in the following:

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

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

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

26 The benefits provided pursuant to this subsection shall be provided
27 to the same extent as for any other medical condition under the health
28 benefits plan, except that [no] a deductible shall not be applied for
29 benefits provided pursuant to this subsection ; however, with respect
30 to a small employer health benefits plan that qualifies as a high
31 deductible health plan for which qualified medical expenses are paid
32 using a health savings account established pursuant to section 223 of
33 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a
34 deductible shall not be applied for any benefits that represent
35 preventive care as permitted by that federal law, and shall not be
36 applied as provided pursuant to section 16 of P.L. .c. (C.)
37 (pending before the Legislature as this bill). This subsection shall
38 apply to all small employer health benefits plans in which the carrier
39 has reserved the right to change the premium.

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

45 m. Effective immediately for a health benefits plan issued on or
46 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and

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

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

16 This subsection shall apply to all small employer health benefits
17 plans in which the carrier has reserved the right to change the
18 premium.

19 n. Effective immediately for a health benefits plan issued on or
20 after the effective date of P.L. , c. (C.) (pending before the
21 Legislature as this bill) and effective on the first 12-month anniversary
22 date of a small employer health benefits plan in effect on the effective
23 date of P.L. , c. (C.) (pending before the Legislature as this
24 bill), the health benefits plans required pursuant to this section that
25 qualify as high deductible health plans for which qualified medical
26 expenses are paid using a health savings account established pursuant
27 to section 223 of the federal Internal Revenue Code of 1986 (26
28 U.S.C. s.223), including any plans offered by a State approved or
29 federally qualified health maintenance organization, shall contain
30 benefits for expenses incurred in connection with any medically
31 necessary benefits provided in-network that represent preventive care
32 as permitted by that federal law.

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

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

40

41 16. (New section) Notwithstanding the provisions of subsection
42 k. of section 3 of P.L.1992, c.162 (C.17B:27A-19) regarding
43 deductibles for a high deductible health plan, a health benefits plan
44 offered pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) on or
45 after the effective date of P.L. , c. (C.) (pending before the
46 Legislature as this bill), that qualifies as a high deductible health plan

1 for which qualified medical expenses are paid using a health savings
2 account established pursuant to section 223 of the federal Internal
3 Revenue Code of 1986 (26 U.S.C. s.223), shall not apply a deductible
4 for any benefits for which a deductible is not applicable pursuant to
5 any law enacted after the effective date of P.L. , c. (C.)
6 (pending before the Legislature as this bill). This section shall apply
7 to all small employer health benefits plans in which the carrier has
8 reserved the right to change the premium.

9
10 17. (New section) A small employer carrier, as a condition of
11 transacting business in this State, may offer, on or after the effective
12 date of P.L. , c. (C.) (pending before the Legislature as this
13 bill), a health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-
14 17 et seq.) that qualifies as a high deductible health plan for which
15 qualified medical expenses are paid using a health savings account
16 established pursuant to section 223 of the federal Internal Revenue
17 Code of 1986 (26 U.S.C. s.223), if that health benefits plan is offered
18 to an eligible small employer that:

19 a. is a policy or contract holder prior to and on or after the
20 effective date of P.L. , c. (C.) (pending before the Legislature
21 as this bill) under a small employer health benefits plan issued pursuant
22 to P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as
23 a high deductible health plan for which qualified medical expenses are
24 paid using a health savings account established pursuant to section 223
25 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223);

26 b. is not a policy or contract holder on or after the effective date
27 of P.L. , c. (C.) (pending before the Legislature as this bill)
28 under a small employer health benefits plan issued pursuant to
29 P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as a
30 high deductible health plan for which qualified medical expenses are
31 paid using a health savings account established pursuant to section 223
32 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) for a
33 period of five years; or

34 c. was not a policy or contract holder under a small employer
35 health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-
36 17 et seq.) prior to the effective date of P.L. , c. (C.)
37 (pending before the Legislature as this bill).

38
39 18. (New section) a. An insurance company, health service
40 corporation, hospital service corporation, medical service corporation
41 or health maintenance organization authorized to issue health benefits
42 plans in this State shall not issue or renew a high deductible health
43 plan for which qualified medical expenses are paid using a health
44 savings account established pursuant to section 223 of the federal
45 Internal Revenue Code of 1986 (26 U.S.C. s.223) on or after the
46 effective date of P.L. , c. (C.) (pending before the Legislature

1 as this bill), unless the application for the contract or policy is
2 accompanied by a written notice, approved by the Commissioner of
3 Banking and Insurance, identifying and containing a one page, double-
4 sided declaration of understanding for high deductible health plans for
5 which qualified medical expenses are paid using a health savings
6 account established pursuant to section 223 of the federal Internal
7 Revenue Code of 1986 (26 U.S.C. s.223). At the time a high
8 deductible health plan for which qualified medical expenses are paid
9 using a health savings account established pursuant to section 223 of
10 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) is issued
11 or renewed, the contract holder or policyholder shall sign and return
12 a copy of the one page, double-sided declaration of understanding to
13 the insurance company, health service corporation, hospital service
14 corporation, medical service corporation or health maintenance
15 organization. The contract holder or policyholder is responsible for
16 retaining a copy of the one page, double-sided declaration of
17 understanding.

18 b. The declaration of understanding shall include a signature line
19 representing the recipient's receipt and understanding of the
20 declaration, and shall also include, but not be limited to, information
21 as to the terms of the plan, presented in plain and simple language,
22 concerning:

- 23 (1) covered services;
- 24 (2) applicable deductibles;
- 25 (3) the responsibility of the contract holder or policyholder and any
26 other covered persons for applicable deductibles;
- 27 (4) claims processing; and
- 28 (5) any other information required by State or federal law.

29 c. The Commissioner of Banking and Insurance shall enforce the
30 provisions of this section. An insurance company, health service
31 corporation, hospital service corporation, medical service corporation
32 or health maintenance organization found in violation of this section
33 shall be liable for a civil penalty of not more than \$1,000 for each day
34 that the payer is in violation if reasonable notice in writing is given of
35 the intent to levy the penalty and, at the discretion of the
36 commissioner, the payer has 30 days, or such additional time as the
37 commissioner shall determine to be reasonable, to remedy the
38 condition which gave rise to the violation and fails to do so within the
39 time allowed. The penalty shall be collected by the commissioner in
40 the name of the State in a summary proceeding in accordance with the
41 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
42 seq.).

43 d. Nothing in this section shall be construed to prohibit the
44 promulgation of regulations by the Commissioner of Banking and
45 Insurance to establish standards for the declaration of understanding
46 required pursuant to this section, which standards may require the

1 declaration of understanding to include additional information not
2 stated in this section as deemed appropriate by the commissioner.

3
4 19. (New section) a. Any health insurer, as a condition of
5 transacting business in this State, offering a contract, policy, or plan
6 that qualifies as a high deductible health plan for which qualified
7 medical expenses are paid using a health savings account established
8 pursuant to section 223 of the federal Internal Revenue Code of 1986
9 (26 U.S.C. s.223), shall provide biannual surveys to the Department
10 of Banking and Insurance, based upon information requested and
11 collected from subscribers, insureds, enrollees, and covered persons
12 covered by qualifying high deductible health plans. Each survey shall
13 request, but is not limited to requesting, information concerning: the
14 income levels of the subscribers, insureds, enrollees, or covered
15 persons, covered by qualifying high deductible health plans; the type
16 of contract, policy, or plan which previously provided coverage to
17 those individuals; the amount of out-of-pocket expenses incurred by
18 those individuals; and the percentage of income used by those
19 individuals to pay deductibles.

20 b. All disclosures made pursuant to this section shall be made in
21 accordance with section 2713 of the "Health Insurance Portability and
22 Accountability Act of 1996," Pub.L.104-191 (42 U.S.C. s.300gg-13).

23

24 20. Section 8 of P.L.1968, c.413 (C.30:4D-8) is amended to read
25 as follows:

26 8. The determination of the method of providing payment of claims
27 under this act shall be made by the State Medicaid Commission on
28 recommendation of the commissioner which method may be:

29 a. (1) By contract, except as prohibited by paragraph (2) of this
30 subsection, with insurance companies incorporated and licensed to do
31 business in the State of New Jersey or with nonprofit health service
32 corporations, dental service corporations, hospital service corporations
33 or medical service corporations, incorporated in New Jersey, and
34 authorized to do business pursuant to P.L.1985, c.236 (C.17:48E-1 et
35 seq.), P.L.1968, c.305 (C.17:48C-1 et seq.), P.L.1938, c.366
36 (C.17:48-1 et seq.) or P.L.1940, c.74 (C.17:48A-1 et seq.), to
37 underwrite, but not for profit, on an insured premium approach, that
38 portion of the program covering all cash grant beneficiaries plus all
39 other State certified recipients of medical assistance within the classes
40 set forth in section 3i. of this act, with the exception of those persons
41 who are confined in institutions for tuberculosis and mental care or
42 who are required by medical necessity to be confined on a presumably
43 permanent basis in other medical care institutions by reason of disease
44 or injury, which contract executed pursuant to this subsection shall
45 provide that for those persons included in the program but not covered
46 on an underwritten basis, the same carrier selected under this

1 subsection shall act as fiscal agent for the department, but not for
2 profit, for such medical assistance benefits as may be available, and
3 any carrier selected pursuant to the provisions of this act is hereby
4 expressly authorized and empowered to undertake the performance of
5 the requirements of such contract.

6 (2) The State Medicaid Commission shall not approve any
7 contract, pursuant to section 11 of P.L.1968, c.413 (C.30:4D-11),
8 with an insurance company or corporation as set forth in paragraph (1)
9 of this subsection that offers to pay all or part of the medical cost of
10 injury, disease or disability of an applicant for or recipient of medical
11 assistance payable under Medicaid using any contract that provides for
12 a deductible which qualifies the contract as a high deductible health
13 plan for which qualified medical expenses are paid using a health
14 savings account established pursuant to section 223 of the federal
15 Internal Revenue Code of 1986 (26 U.S.C. s.223).

16 b. (1) By contract, except as prohibited by paragraph (2) of this
17 subsection, with any corporation doing business in the State of New
18 Jersey, including nonprofit organizations incorporated in New Jersey
19 and authorized to do business pursuant to P.L.1985, c.236
20 (C.17:48E-1 et seq.), P.L.1968, c.305 (C.17:48C-1 et seq.), P.L.1938,
21 c.366 (C. 7:48-1 et seq.) or P.L.1940, c.74 (C.17:48A-1 et seq.), to
22 act as fiscal agent.

23 (2) The State Medicaid Commission shall not direct that payment
24 of claims be made by the Department of Human Services, pursuant to
25 section 11 of P.L.1968, c.413 (C.30:4D-11), with a corporation or
26 nonprofit organization as set forth in paragraph (1) of this subsection
27 that offers to pay all or part of the medical cost of injury, disease or
28 disability of an applicant for or recipient of medical assistance payable
29 under Medicaid using any contract that provides for a deductible
30 which qualifies the contract as a high deductible health plan for which
31 qualified medical expenses are paid using a health savings account
32 established pursuant to section 223 of the federal Internal Revenue
33 Code of 1986 (26 U.S.C. s.223).

34 c. By direct administration by the Department of Human Services.
35 (cf: P.L.1988, c.6, s.2)

36
37 21. (New Section). The Commissioner of Human Services shall
38 not utilize or establish any contract that provides for a deductible
39 which qualifies the contract as a high deductible health plan for which
40 qualified medical expenses are paid using a health savings account
41 established pursuant to section 223 of the federal Internal Revenue
42 Code of 1986 (26 U.S.C. s.223) in the implementation and operation
43 of the NJ FamilyCare Program, established pursuant to sections 3
44 through 5 of P.L.2005, c.156 (C.30:4J-10 through C.30:4J-12).

45
46 22. (New section) a. Notwithstanding the purposes of the "Lead

1 Hazard Control Assistance Fund" provided by P.L.2003, c.311
2 (C.52:27D-437.1 et al.), the Commissioner of Community Affairs shall
3 transfer to the Division of Medical Assistance and Health Services in
4 the Department of Human Services from the "Lead Hazard Control
5 Assistance Fund" established pursuant to section 4 of P.L.2003, c.311
6 (C.52:27D-437.4), upon certification by the director of the division
7 pursuant to paragraph (2) of subsection d. of this section, an amount
8 not to exceed \$500,000 annually in each fiscal year following the
9 effective date of P.L. , c. (C.) (pending before the
10 Legislature as this bill), to fund the costs incurred by licensed health
11 care facilities and licensed health care providers for any necessary
12 medical follow-up and treatment for lead poisoned children covered
13 under a contract, policy, or plan that qualifies as a high deductible
14 health plan for which qualified medical expenses are paid using a
15 health savings account established pursuant to section 223 of the
16 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), as provided
17 in this section.

18 b. The division shall administer a claim reimbursement program to
19 reimburse licensed health care facilities and licensed health care
20 providers for their costs incurred in providing services pursuant to
21 subsection c. of this section for any necessary medical follow-up and
22 treatment of lead poisoned children: (1) whose family income does not
23 exceed 400% of the federal poverty level; (2) who are eligible to
24 receive benefits under a contract, policy, or plan that qualifies as a
25 high deductible health plan for which qualified medical expenses are
26 paid using a health savings account established pursuant to section 223
27 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223); and
28 (3) for whom the deductible limits of that contract, policy, or plan
29 have not been exceeded.

30 c. Licensed health care facilities and licensed health care providers
31 shall provide necessary medical follow-up and treatment of lead
32 poisoned children:(1) whose family income does not exceed 400% of
33 the federal poverty level; (2) who are covered under a contract, policy,
34 or plan that qualifies as a high deductible health plan for which
35 qualified medical expenses are paid using a health savings account
36 established pursuant to section 223 of the federal Internal Revenue
37 Code of 1986 (26 U.S.C. s.223); and (3) for whom the deductible
38 limits of that contract, policy, or plan are not exceeded. Licensed
39 health care facilities and licensed health care providers shall not seek
40 reimbursement for any costs incurred pursuant to this subsection from
41 the insureds covered under a contract, policy, or plan that qualifies as
42 a high deductible health plan for which medical expenses are paid
43 using a health savings account established pursuant to section 223 of
44 the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) or the
45 carrier that issued the high deductible health plan for which medical
46 expenses are paid using a health savings account established pursuant

1 to section 223 of the federal Internal Revenue Code of 1986 (26
2 U.S.C. s.223).

3 d. (1) Licensed health care facilities and licensed health care
4 providers shall submit claims for necessary medical follow-up and
5 treatment cost reimbursement to the division in a form and manner as
6 prescribed by the director by regulation.

7 (2) The director of the division shall, at least once every other
8 month, or more frequently as provided by regulation, certify the
9 amount of reimbursement claims submitted by licensed health care
10 facilities and licensed health care providers and forward the
11 certification to the Commissioner of Community Affairs. The
12 commissioner shall, upon receipt of the certification, immediately
13 transfer the specified amount of funds, not to exceed \$500,000
14 annually, from the "Lead Hazard Control Assistance Fund" established
15 pursuant to section 4 of P.L.2003, c.311 (C.52:27D-437.4) to the
16 division.

17 (3) Upon receipt of the funds, the division shall provide
18 reimbursements for services provided pursuant to subsection c. of this
19 section to the licensed health care facilities and licensed health care
20 providers at the Medicaid rate.

21

22 23. (New section) a. The Commissioner of Banking and Insurance
23 shall monitor the implementation and effect of P.L. , c. (C.)
24 (pending before the Legislature as this bill) on the health insurance
25 marketplace and shall report to the Governor, the Legislature, and the
26 committees as provided in subsection c. of this section, no later than:
27 12 months after the effective date of this act with an initial report; and
28 24 months after the effective date of this act with a final report
29 containing the commissioner's findings.

30 b. The commissioner's initial and final reports may include, but
31 shall not be limited to, information concerning: the number of
32 insurance carriers offering only contracts, policies or plans that qualify
33 as high deductible health plans for which qualified medical expenses
34 are paid using a health savings account established pursuant to section
35 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223);
36 the deductible amounts applicable to those plans; any adverse selection
37 by subscribers, insureds, enrollees, or covered persons relative to
38 those plans; any increase in cost shifting to the subscribers, insureds,
39 enrollees, or covered persons covered by those plans; any increase in
40 cost shifting to publicly funded health programs for expenses incurred
41 in treating subscribers, insureds, enrollees, or covered persons covered
42 by those plans; and the data contained in the biannual surveys provided
43 by insurance carriers to the Department of Banking and Insurance as
44 required by section 19 of this act. The final report shall also include
45 the commissioner's recommendation for any legislative reforms
46 deemed appropriate by the commissioner.

1 c. The Senate Health, Human Services and Senior Citizens
2 Committee and the General Assembly Health and Human Services
3 Committee, or their respective successors, are each charged with
4 monitoring and evaluating the effect of the provisions of P.L. ,
5 c. (C.) (pending before the Legislature as this bill) on the
6 insurance marketplace. The Commissioner of Banking and Insurance
7 shall, no later than 24 months after the effective date of P.L. , c.
8 (C.) (pending before the Legislature as this bill), present the
9 findings of the commissioner's final report prepared pursuant to
10 subsection a. of this section before each committee, which committee
11 meetings shall be open to the public and include public comment
12 periods. The committees shall, upon receiving the final report
13 prepared pursuant to subsection a. of this section, and the testimony
14 of the commissioner and the public provided pursuant to this
15 subsection, issue as it may deem necessary and proper,
16 recommendations for administrative or legislative changes affecting the
17 implementation of P.L. , c. (C.) (pending before the
18 Legislature as this bill).

19

20 24. This act shall take effect on December 31, 2005 and shall apply
21 to all contracts and policies that are delivered, issued, executed or
22 renewed or approved for issuance or renewal in this State on or after
23 the effective date.

24

25

26

STATEMENT

27

28 This bill facilitates the establishment of health savings accounts in
29 this State. The federal "Medicare Prescription Drug, Improvement
30 and Modernization Act of 2003," Pub. L. 108-173, allows eligible
31 individuals who are enrolled in a qualified high deductible health plan
32 to establish health savings accounts (HSA's) beginning January 1,
33 2004. Contributions to HSA's receive favorable tax treatment in that
34 they may be accumulated over the years, or distributed on a tax-free
35 basis, to pay or reimburse qualifying medical expenses.

36 However, because of the requirements of the federal law, current
37 provisions of existing State law, which require that certain non-
38 preventive care or treatment under health insurance contracts and
39 policies be provided without the application of a deductible, must be
40 modified in order that HSA's may be continuously offered in this State
41 after December 31, 2005. The federal law provided states with a two-
42 year transition period, ending December 31, 2005, in order to
43 accomplish any necessary modifications in State law to allow for the
44 establishment and continuation of HSA's.

45 Therefore, to comply with federal law, the bill prohibits the
46 application of a deductible for any "medically necessary" benefit
47 provided in-network that has been deemed under the applicable federal

1 law to represent preventive care, if the benefit is provided under a high
2 deductible health plan linked to an HSA. However, notwithstanding
3 this provision and absent any subsequent legislative reforms to the
4 contrary, the bill prohibits the application of a deductible for any
5 benefit if, after the effective date of the bill, the Legislature enacts a
6 law that prohibits the application of a deductible to any benefit,
7 whether or not "medically necessary," preventive, or provided in-
8 network, covered under any health insurance policy.

9 The provisions of the bill allow a deductible to apply to necessary
10 medical follow-up and treatment for lead poisoned children covered
11 under a high deductible health plan linked to an HSA. Under current
12 law, these services are exempted from incurring a deductible.
13 However, so as to not thwart the availability of treatment of lead
14 poisoned children for families who cannot afford a deductible payment,
15 the bill requires that health care facilities and providers provide all
16 necessary medical follow-up and treatment of lead poisoned children:
17 (1) whose family income does not exceed 400% of the federal poverty
18 level; (2) who are eligible to receive benefits under a high deductible
19 health plan for which qualified expenses are paid using a health savings
20 account; and (3) for whom the deductible limits of that plan have not
21 yet been exceeded. The facilities and providers shall not seek
22 reimbursement for the delivery of qualified services from either the
23 insured or under the high deductible health plan.

24 Health care facilities and providers that incur expenses pursuant to
25 these provisions may submit a claim to a claim reimbursement program
26 managed by the Division of Medical Assistance and Health Services in
27 the Department of Human Services. Facilities and providers shall be
28 reimbursed at the Medicaid rate. To fund the reimbursement program,
29 an amount not to exceed \$500,000 each fiscal year shall be transferred
30 from the "Lead Hazard Control Assistance Fund," established pursuant
31 to section 4 of P.L.2003, c.311 (C.52:27D-437.4).

32 The bill also prohibits the use of high deductible health plans with
33 respect to the administration of Medicaid in this State and the NJ
34 FamilyCare Program.

35 All health insurance carriers offering high deductible health plans
36 are required to provide a written notice, approved by the
37 Commissioner of Banking and Insurance, with any application for a
38 high deductible health plan contract or policy. The notice, known as
39 a declaration of understanding, shall include a signature line
40 representing the recipient's receipt and understanding of the
41 declaration, and include information as to the terms of the high
42 deductible health plan, such as covered services, applicable
43 deductibles, and claims processing. The commissioner shall enforce
44 this notice requirement, which if violated carries a civil penalty of not
45 more than \$1,000 for each day that the carrier is in violation of the
46 applicable bill provisions.

47 All health insurance carriers offering high deductible health plans

1 are also required to provide the Department of Banking and Insurance
2 with biannual surveys, based upon information requested and collected
3 from subscribers, insureds, enrollees, and covered persons of such
4 plans. These surveys are intended to gather information concerning
5 the impact of high deductible health plans on those individuals covered
6 by such plans.

7 With respect to small employer carriers, the bill permits such
8 carriers to offer high deductible health plans only to small employers
9 that: 1) currently offer health benefits plans other than a high
10 deductible health plan; 2) previously offered health benefits plans other
11 than a high deductible health plan, but have not offered any such plan
12 for a period of five years; or 3) never before offered any type of health
13 benefits plan.

14 Finally, the bill provides that the Commissioner of Banking and
15 Insurance shall monitor the implementation of the bill and report to the
16 Governor and certain members of the Legislature information
17 concerning the prevalence of high deductible health plans in the
18 marketplace, and any effect on the insurance coverage rates in the
19 State or enrollment rates in State-funded medical assistance programs.

SENATE, No. 2574

STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED MAY 19, 2005

Sponsored by:

Senator RONALD L. RICE

District 28 (Essex)

Senator ANTHONY R. BUCCO

District 25 (Morris)

SYNOPSIS

Provides for establishment of health savings accounts.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 9/27/2005)

1 AN ACT concerning health savings accounts and amending and
2 supplementing various parts of the statutory law.

3

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

6

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

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

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

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

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

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

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

Matter underlined thus is new matter.

1 may be applied. This section shall apply to all health service
2 corporation contracts in which the health service corporation has
3 reserved the right to change the premium.

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

5
6 2. (New Section) A contract offered by a health service
7 corporation that would otherwise qualify as a high deductible health
8 plan issued in conjunction with a health savings account established
9 pursuant to section 223 of the federal Internal Revenue Code of 1986
10 (26 U.S.C.s.223) may apply annual deductible amounts as would be
11 required to qualify as a high deductible health plan under that section,
12 notwithstanding any other law to the contrary.

13
14 3. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
15 as follows:

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

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

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

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

44 The benefits provided pursuant to this section shall be provided to
45 the same extent as for any other medical condition under the contract,
46 except that no deductible shall be applied for benefits provided

1 pursuant to this section; provided, however, that with respect to a
2 contract that is a high deductible health plan issued in conjunction with
3 a health savings account established pursuant to section 223 of the
4 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible
5 may be applied. This section shall apply to all hospital service
6 corporation contracts in which the hospital service corporation has
7 reserved the right to change the premium.

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

9

10 4. (New Section) A contract offered by a hospital service
11 corporation that would otherwise qualify as a high deductible health
12 plan issued in conjunction with a health savings account established
13 pursuant to section 223 of the federal Internal Revenue Code of 1986
14 (26 U.S.C.s.223) may apply annual deductible amounts as would be
15 required to qualify as a high deductible health plan under that section,
16 notwithstanding any other law to the contrary.

17

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

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

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

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

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

1 The benefits provided pursuant to this section shall be provided to
2 the same extent as for any other medical condition under the policy,
3 except that no deductible shall be applied for benefits provided
4 pursuant to this section; provided, however, that with respect to a
5 policy that is a high deductible health plan issued in conjunction with
6 a health savings account established pursuant to section 223 of the
7 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible
8 may be applied. This section shall apply to all group health insurance
9 policies in which the health insurer has reserved the right to change the
10 premium.

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

12

13 6. (New Section) A group health insurance policy that would
14 otherwise qualify as a high deductible health plan issued in conjunction
15 with a health savings account established pursuant to section 223 of
16 the federal Internal Revenue Code of 1986 (26 U.S.C.s.223) may
17 apply annual deductible amounts as would be required to qualify as a
18 high deductible health plan under that section, notwithstanding any
19 other law to the contrary.

20

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

23 4. A certificate of authority to establish and operate a health
24 maintenance organization in this State shall not be issued or continued
25 by the Commissioner of Health and Senior Services on or after the
26 effective date of this act unless the health maintenance organization
27 offers health care services to any enrollee which include:

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

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

42 c. Screening for newborn hearing loss by appropriate
43 electrophysiologic screening measures and periodic monitoring of
44 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
45 (C.26:2-103.1 et al.). Payment for this screening service shall be
46 separate and distinct from payment for routine new baby care in the

1 form of a newborn hearing screening fee as negotiated with the
2 provider and facility.

3 The health care services provided pursuant to this section shall be
4 provided to the same extent as for any other medical condition under
5 the contract, except that no deductible shall be applied for services
6 provided pursuant to this section; ~~provided, however, that with respect~~
7 ~~to a contract that is a high deductible health plan issued in conjunction~~
8 ~~with a health savings account established pursuant to section 223 of~~
9 ~~the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a~~
10 ~~deductible may be applied.~~ This section shall apply to all contracts
11 under which the health maintenance organization has reserved the right
12 to change the schedule of charges for enrollee coverage.
13 (cf: P.L.2001, c.373, s.13).

14
15 8. (New section) A contract offered by a health maintenance
16 organization that would otherwise qualify as a high deductible health
17 plan issued in conjunction with a health savings account established
18 pursuant to section 223 of the federal Internal Revenue Code of 1986
19 (26 U.S.C.s.223) may apply annual deductible amounts as would be
20 required to qualify as a high deductible health plan under that section,
21 notwithstanding any other law to the contrary.

22
23 9. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read
24 as follows:

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

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

45 b. An individual health benefits plan offered pursuant to section 3
46 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no

1 more than 12 months on coverage for preexisting conditions. An
2 individual health benefits plan offered pursuant to section 3 of
3 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
4 condition limitation of any period under the following circumstances:

5 (1) to an individual who has, under creditable coverage, with no
6 intervening lapse in coverage of more than 31 days, been treated or
7 diagnosed by a physician for a condition under that plan or satisfied a
8 12-month preexisting condition limitation; or

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

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

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

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

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

41 (2) All childhood immunizations as recommended by the Advisory
42 Committee on Immunization Practices of the United States Public
43 Health Service and the Department of Health and Senior Services
44 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
45 shall notify its insureds, in writing, of any change in the health care
46 services provided with respect to childhood immunizations and any

1 related changes in premium. Such notification shall be in a form and
2 manner to be determined by the Commissioner of Banking and
3 Insurance.

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

11 The benefits provided pursuant to this section shall be provided to
12 the same extent as for any other medical condition under the health
13 benefits plan, except that no deductible shall be applied for benefits
14 provided pursuant to this subsection; provided, however, that with
15 respect to a health benefits plan that is a high deductible health plan
16 issued in conjunction with a health savings account established
17 pursuant to section 223 of the federal Internal Revenue Code of 1986
18 (26 U.S.C. s.223), a deductible may be applied. This subsection shall
19 apply to all individual health benefits plans in which the carrier has
20 reserved the right to change the premium.

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

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

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

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

41

42 10. (New section) A health benefits plan offered pursuant to
43 P.L.1992, c.161 (C.17B:27A-2 et seq.) that would otherwise qualify
44 as a high deductible health plan issued in conjunction with a health
45 savings account established pursuant to section 223 of the federal
46 Internal Revenue Code of 1986 (26 U.S.C.s.223) may apply annual

1 deductible amounts as would be required to qualify as a high
2 deductible health plan under that section, notwithstanding any other
3 law to the contrary.

4

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

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

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

28 At least three of the forms shall provide for major medical benefits
29 in varying lifetime aggregates, one of which shall provide at least
30 \$1,000,000 in lifetime aggregate benefits. The policy forms provided
31 pursuant to this section shall contain benefits representing
32 progressively greater actuarial values.

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

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

1 requirements of the plan shall be issued a policy or contract by the
2 carrier.

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

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

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

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

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

41 g. A carrier shall not be required to own or control a health
42 maintenance organization or otherwise affiliate with a health
43 maintenance organization in order to comply with the provisions of
44 this section, but the carrier shall be required to offer the five health
45 benefits plans which are formulated by the board and approved by the
46 commissioner, including one plan which contains benefits and cost

1 sharing levels that are equivalent to those required for health
2 maintenance organizations.

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

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

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

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

31 j. (1) Notwithstanding the provisions of P.L.1992, c.162
32 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
33 by or through a carrier, association, or multiple employer arrangement
34 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
35 paragraph (6) of this subsection are met, issued by or through an
36 out-of-State trust prior to January 1, 1994, at the option of a small
37 employer policy or contract holder, may be renewed or continued after
38 February 28, 1994, or in the case of such a health benefits plan whose
39 anniversary date occurred between March 1, 1994 and the effective
40 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
41 within 60 days of that anniversary date and renewed or continued if,
42 beginning on the first 12-month anniversary date occurring on or after
43 the sixtieth day after the board adopts regulations concerning the
44 implementation of the rating factors permitted by section 9 of
45 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
46 delivery of the health benefits plan, the health benefits plan renewed,

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

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

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

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

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

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

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

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

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

45 (5) A health benefits plan that otherwise conforms to the
46 requirements of this subsection shall be deemed to be in compliance

1 with this subsection, notwithstanding any change in the plan's
2 deductible or copayment.

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

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

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

41 (7) Notwithstanding the provisions of P.L.1992, c.162
42 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
43 employer arrangement or out-of-State trust may offer a health benefits
44 plan authorized to be renewed, continued or reinstated pursuant to this
45 subsection to small employer groups that are otherwise eligible
46 pursuant to paragraph (1) of subsection j. of this section during the

1 period for which such health benefits plan is otherwise authorized to
2 be renewed, continued or reinstated.

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

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

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

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

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

43 Notwithstanding the provisions of subparagraph (b) of paragraph
44 (6) of this subsection to the contrary, a small employer who changes
45 its health benefits plan's issuing carrier pursuant to the provisions of
46 this paragraph, shall not, upon changing carriers, modify the benefit

1 structure of that health benefits plan within six months of the date the
2 issuing carrier was changed.

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

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

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

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

32 The benefits provided pursuant to this section shall be provided to
33 the same extent as for any other medical condition under the health
34 benefits plan, except that no deductible shall be applied for benefits
35 provided pursuant to this subsection; provided, however, that with
36 respect to a health benefits plan that is a high deductible health plan
37 issued in conjunction with a health savings account established
38 pursuant to section 223 of the federal Internal Revenue Code of 1986
39 (26 U.S.C. s.223), a deductible may be applied. This subsection shall
40 apply to all small employer health benefits plans in which the carrier
41 has reserved 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.2001, c.361 (C.17:48-6z et al.) and
3 effective on the first 12-month anniversary date of a health benefits
4 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et
5 al.), the health benefits plans required pursuant to this section that
6 provide benefits for expenses incurred in the purchase of prescription
7 drugs shall provide benefits for expenses incurred in the purchase of
8 specialized non-standard infant formulas, when the covered infant's
9 physician has diagnosed the infant as having multiple food protein
10 intolerance and has determined such formula to be medically
11 necessary, and when the covered infant has not been responsive to
12 trials of standard non-cow milk-based formulas, including soybean and
13 goat milk. The coverage may be subject to utilization review,
14 including periodic review, of the continued medical necessity of the
15 specialized infant formula.

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

18 This subsection shall apply to all small employer health benefits
19 plans in which the carrier has reserved the right to change the
20 premium.

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

22

23 12. (New section) A health benefits plan offered pursuant to
24 P.L.1992, c.162 (C.17B:27A-17 et seq.) that would otherwise qualify
25 as a high deductible health plan issued in conjunction with a health
26 savings account established pursuant to section 223 of the federal
27 Internal Revenue Code of 1986 (26 U.S.C.s.223) may apply annual
28 deductible amounts as would be required to qualify as a high
29 deductible health plan under that section, notwithstanding any other
30 law to the contrary.

31

32 13. This act shall take effect on the 30th day after enactment and
33 shall apply to all contracts and policies that are delivered, issued,
34 executed or renewed or approved for issuance or renewal in this State
35 on or after the effective date.

36

37

38

STATEMENT

39

40 This bill facilitates the establishment of health savings accounts in
41 this State. The federal "Medicare Prescription Drug, Improvement
42 and Modernization Act of 2003," (Pub. L. 108-173) allows eligible
43 individuals to establish health savings accounts beginning January 1,
44 2004. Contributions to health savings accounts receive favorable tax
45 treatment in that they may be accumulated over the years, or
46 distributed on a tax-free basis, to pay or reimburse qualifying medical

1 expenses. To establish such an account, an individual must be enrolled
2 in a high deductible health plan as defined in the federal law.

3 However, because of the requirements of the federal law, current
4 provisions of existing State law, which require that certain non-
5 preventive care or treatment under health insurance contracts and
6 policies be provided without the application of a deductible, must be
7 modified in order that health savings accounts may be continuously
8 offered in this State after December 31, 2005. The federal law
9 provides the states with a two-year transition period, in order to
10 accomplish any necessary modifications in State law to allow for the
11 establishment and continuation of health savings accounts.

SENATE, No. 2435

STATE OF NEW JERSEY
211th LEGISLATURE

INTRODUCED MARCH 21, 2005

Sponsored by:

Senator THOMAS H. KEAN, JR.

District 21 (Essex, Morris, Somerset and Union)

SYNOPSIS

Provides for establishment of health savings accounts.

CURRENT VERSION OF TEXT

As introduced.



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

3

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

6

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

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

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

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

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

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

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

Matter underlined thus is new matter.

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

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

5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40

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

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

1 effective date of this act unless the health maintenance organization
2 offers health care services to any enrollee which include:

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

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

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

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

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

35

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

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

1 (C.54A:3-4 et al.). The board shall provide the commissioner with an
2 informational filing of the policy and contract forms and benefit levels
3 it establishes.

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

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

18 (1) to an individual who has, under creditable coverage, with no
19 intervening lapse in coverage of more than 31 days, been treated or
20 diagnosed by a physician for a condition under that plan or satisfied a
21 12-month preexisting condition limitation; or

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

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

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

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

1 health maintenance organization, shall contain benefits for expenses
2 incurred in the following:

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

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

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

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

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

1 utilization review, including periodic review, of the continued medical
2 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 individual health benefits plans in
6 which the carrier has reserved the right to change the premium.

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

8

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

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

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

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

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

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

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

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

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

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

37 Notwithstanding the provisions of this section to the contrary, a
38 health maintenance organization which is approved pursuant to
39 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
40 benefits plans formulated by the board and approved by the
41 commissioner which are in accordance with the provisions of that law
42 in lieu of the five plans required pursuant to this section, except that
43 the plans shall provide the same level of benefits as required for a
44 federally qualified health maintenance organization, including any
45 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
14 d. 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-19, 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, or 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-19,
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 burden to the issuing carrier, taking
42 into account the rating provisions of section 9 of P.L.1992, c.162
43 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

44 (b) A carrier which has renewed, continued or reinstated a health
45 benefits plan pursuant to this subsection that has not been newly issued
46 to a new small employer group since January 1, 1994, may, upon

1 approval of the commissioner, continue to establish its rates for that
2 plan based on the loss experience of that plan if the carrier does not
3 issue that health benefits plan to any new small employer groups.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 health benefits plans in which the carrier has reserved the right to
2 change the premium.

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

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

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

25 This subsection shall apply to all small employer health benefits
26 plans in which the carrier has reserved the right to change the
27 premium.

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

29

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

34

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STATEMENT

37

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

1 However, because of the requirements of the federal law, current
2 provisions of existing State law, which require that certain non-
3 preventive care or treatment under health insurance contracts and
4 policies be provided without the application of a deductible, must be
5 modified in order that health savings accounts may be continuously
6 offered in this State after December 31, 2005. The federal law
7 provides the states with a two-year transition period, in order to
8 accomplish any necessary modifications in State law to allow for the
9 establishment and continuation of health savings accounts.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR **SENATE, Nos. 2574 and 2435**

STATE OF NEW JERSEY

DATED: DECEMBER 5, 2005

The Senate Commerce Committee reports favorably a Senate Committee Substitute for Senate Bill Nos. 2574 and 2435.

The proposed Senate Committee Substitute facilitates the establishment of health savings accounts in this State. The federal "Medicare Prescription Drug, Improvement and Modernization Act of 2003," Pub. L. 108-173, allows eligible individuals who are enrolled in a qualified high deductible health plan to establish health savings accounts (HSA's) beginning January 1, 2004. Contributions to HSA's receive favorable tax treatment in that they may be accumulated over the years, or distributed on a tax-free basis, to pay or reimburse qualifying medical expenses.

However, because of the requirements of the federal law, current provisions of existing State law, which require that certain non-preventive care or treatment under health insurance contracts and policies be provided without the application of a deductible, must be modified in order that HSA's may be continuously offered in this State after December 31, 2005. The federal law provides the states with a two-year transition period, in order to accomplish any necessary modifications in State law to allow for the establishment and continuation of HSA's.

Therefore, to comply with federal law, this substitute prohibits the application of a deductible for any benefit that has been deemed under the applicable federal law to represent preventive care, if the benefit is provided under a high deductible health plan linked to an HSA. However, notwithstanding this provision and absent any subsequent legislative reforms to the contrary, the substitute prohibits the application of a deductible for any benefit if, after the effective date of this substitute, the Legislature enacts a law that prohibits the application of a deductible to any benefit, whether or not preventive, covered under any health insurance policy.

The provisions of this substitute allow a deductible to apply to necessary medical follow-up and treatment for lead poisoned children covered under a high deductible health plan linked to an HSA. Under current law, these services are exempted from incurring a deductible.

However, so as to not thwart the availability of treatment of lead poisoned children for families who cannot afford a deductible payment, the substitute requires that health care facilities and providers provide all necessary medical follow-up and treatment of lead poisoned children: (1) whose family income does not exceed 400% of the federal poverty level; (2) who are eligible to receive benefits under a high deductible health plan that qualifies for a health savings account; and (3) for whom the deductible limits of that plan have not yet been exceeded. The facilities and providers shall not seek reimbursement for the delivery of qualified services from either the insured or under the high deductible health plan.

Health care facilities and providers that incur expenses pursuant to these provisions, may submit a claim to a claim reimbursement program managed by the Division of Medical Assistance and Health Services in the Department of Human Services. Facilities and providers shall be reimbursed at the Medicaid rate. To fund the reimbursement program, an amount not to exceed \$500,000 each fiscal year shall be transferred from the "Lead Hazard Control Assistance Fund," established pursuant to section 4 of P.L.2003, c.311 (C.52:27D-437.4).

The substitute would also prohibit the use of high deductible health plans with respect to the administration of Medicaid in this State and the NJ FamilyCare Program.

Finally, the substitute provides that the Commissioner of Banking and Insurance shall monitor the implementation of this substitute and report to the Governor and certain members of the Legislature information concerning the prevalence of high deductible health plans in the marketplace and any effect on the insurance coverage rates in the State or enrollment rates in State-funded medical assistance programs. In addition, the commissioner is directed to approve and enforce the use of carrier-created one-page, double-sided declarations of understanding, to be included with any high deductible health plan application, which explains in plain and simple language certain terms of the plan, including covered services, applicable deductibles, and claims processing.