CHAPTER 248

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

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

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

C.17:48E-35.10 Health service corporation contracts, child screening, blood lead, hearing loss; immunizations.

1. No health service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

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

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

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

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 3 of P.L.2005, c.248 (C.17:48E-35.28). This section shall apply to all health service corporation contracts in which the health service corporation has reserved the right to change the premium.

C.17:48E-35.27 Health service corporation, high deductible, coverage for preventive care.

2. No health service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in connection with any medically necessary benefits provided in-network that represent preventive care as permitted by that federal law.

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

C.17:48E-35.28 Health service corporation, high deductible, deductible inapplicable, certain circumstances.

3. Notwithstanding the provisions of section 1 of P.L.1995, c.316 (C.17:48E-35.10) regarding deductibles for a high deductible health plan, a contract offered by a health service corporation providing hospital or medical expense benefits for groups with greater than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), shall not apply a deductible for any benefits for which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

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

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

C.17:48-6m Hospital service corporation contracts, child screening, blood lead, hearing loss; immunizations.

2. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

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

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

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

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 6 of P.L.2005, c.248 (C.17:48-6.dd). This section shall apply to all hospital service corporation contracts in which the health service corporation has reserved the right to change the premium.

C.17:48-6cc Hospital service corporation, high deductible, coverage for preventive care.

5. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to

section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in connection with any medically necessary benefits provided in-network that represent preventive care as permitted by that federal law.

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

C.17:48-6dd Hospital service corporation, high deductible, deductible inapplicable, certain circumstances.

6. Notwithstanding the provisions of section 2 of P.L.1995, c.316 (C.17:48-6m) regarding deductibles for a high deductible health plan, a contract offered by a hospital service corporation providing hospital or medical expense benefits for groups with greater than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), shall not apply a deductible for any benefits for which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

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

7. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to read as follows:

C.17B:27-46.11 Group health insurance policy, child screening, blood lead, hearing loss; immunizations.

3. No group health insurance policy providing hospital or medical expense benefits for groups with more than 50 persons shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in the following:

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

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

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

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the policy, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a policy that qualifies as a

high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 9 of P.L.2005, c.248 (C.17B:27-46.1dd). This section shall apply to all group health insurance policies in which the health insurer has reserved the right to change the premium.

C.17B:27-46.1cc Group health insurance policy, high deductible, coverage for preventive care.

8. No group health insurance policy providing hospital or medical expense benefits for groups with more than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

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

C.17B:27-46.1dd Group health insurance policy, high deductible, deductible inapplicable, certain circumstances.

9. Notwithstanding the provisions of section 3 of P.L.1995, c.316 (C.17B:27-46.1l) regarding deductibles for a high deductible health plan, a group health insurance policy providing hospital or medical expense benefits for groups with more than 50 persons, that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), and that is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), shall not apply a deductible for any benefits for which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

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

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

C.26:2J-4.10 Health maintenance organization, child screening, blood lead, hearing loss; immunizations.

4. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) unless the health maintenance organization offers health care services to any enrollee which include:

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

b. All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health and Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health maintenance organization shall notify its enrollees, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium.

Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

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

The health care services provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for services provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any services provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 12 of P.L.2005, c.248 (C.26:2J-4.29). This section shall apply to all contracts under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

C.26:2J-4.28 Health maintenance organization, high deductible, coverage for preventive care.

11. A certificate of authority to establish and operate a health maintenance organization, which organization offers a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the health maintenance organization offers health care services to any enrollee which include services provided in-network which represent medically necessary preventive care as permitted by that federal law.

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

C.26:2J-4.29 Health maintenance organization, high deductible, deductible inapplicable, certain circumstances.

12. Notwithstanding the provisions of section 4 of P.L.1995, c.316 (C.26:2J-4.10) regarding deductibles for a high deductible health plan, a contract offered by a health maintenance organization, which certificate of authority to establish and operate is issued or continued by the Commissioner of Health and Senior Services on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not apply a deductible for any benefits in which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

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

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

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

6. The board shall establish the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability

Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The board shall provide the commissioner with an informational filing of the policy and contract forms and benefit levels it establishes.

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

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

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

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

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

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

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

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

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

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

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health

benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

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

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

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

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

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

C.17B:27A-7.11 Individual health benefits plan, high deductible, deductible inapplicable, certain circumstances.

14. Notwithstanding the provisions of subsection e. of section 6 of P.L.1992, c.161 (C.17B:27A-7) regarding deductibles for a high deductible health plan, a health benefits plan offered pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C.s.223), shall not apply a deductible for any benefits for which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.). This section shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

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

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

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer the five health

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

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

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

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

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

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

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

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

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

Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is approved pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the five plans

required pursuant to this section, except that the plans shall provide the same level of benefits as required for a federally qualified health maintenance organization, including any requirements concerning copayments by enrollees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.17B:27A-19.14 High deductible health plan, small employer, deductible inapplicable, certain circumstances.

16. Notwithstanding the provisions of subsection k. of section 3 of P.L.1992, c.162 (C.17B:27A-19) regarding deductibles for a high deductible health plan, a health benefits plan offered pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not apply a deductible for any benefits for which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.). This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the

premium.

C.17B:27A-19a Small employer carrier, offering of high deductible plan.

17. A small employer carrier, as a condition of transacting business in this State, may offer, on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), a health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), if that health benefits plan is offered to an eligible small employer that:

a. is a policy or contract holder prior to and on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) under a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223);

b. is not a policy or contract holder on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) under a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) which does not qualify as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) for a period of five years; or

c. was not a policy or contract holder under a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) prior to the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

C.17B:27A-55 Written notice required for issuance, renewal of high deductible health plan; declaration of understanding.

18. a. An insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State shall not issue or renew a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the application for the contract or policy is accompanied by a written notice, approved by the Commissioner of Banking and Insurance, identifying and containing a one page, double-sided declaration of understanding for high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). At the time a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) is issued or renewed, the contract holder or policyholder shall sign and return a copy of the one page, double-sided declaration of understanding to the insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization. The contract holder or policyholder is responsible for retaining a copy of the one page, double-sided declaration of understanding.

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

(1) covered services;

(2) applicable deductibles;

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

(4) claims processing; and

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

c. The Commissioner of Banking and Insurance shall enforce the provisions of this section. An insurance company, health service corporation, hospital service corporation, medical service

corporation or health maintenance organization found in violation of this section shall be liable for a civil penalty of not more than $1,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

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

C.17B:27A-56 Provision of biannual surveys to DOBI by health insurers.

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

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

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

C.30:4D-8 Claim payment method.

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

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

(2) The State Medicaid Commission shall not approve any contract, pursuant to section 11 of P.L.1968, c.413 (C.30:4D-11), with an insurance company or corporation as set forth in

paragraph (1) of this subsection that offers to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under Medicaid using any contract that provides for a deductible which qualifies the contract as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223).

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

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

c. By direct administration by the Department of Human Services.

C.30:4J-12.1 NJ FamilyCare Program, high deductible contract prohibited.

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

C.26:2H-18.71 Funding of health care treatment for lead poisoned children.

22. a. Notwithstanding the purposes of the "Lead Hazard Control Assistance Fund" provided by P.L.2003, c.311 (C.52:27D-437.1 et al.), the Commissioner of Community Affairs shall transfer to the Division of Medical Assistance and Health Services in the Department of Human Services from the "Lead Hazard Control Assistance Fund" established pursuant to section 4 of P.L.2003, c.311 (C.52:27D-437.4), upon certification by the director of the division pursuant to paragraph (2) of subsection d. of this section, an amount not to exceed $500,000 annually in each fiscal year following the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), to fund the costs incurred by licensed health care facilities and licensed health care providers for any necessary medical follow-up and treatment for lead poisoned children covered under a contract, policy, or plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), as provided in this section.

b. The division shall administer a claim reimbursement program to reimburse licensed health care facilities and licensed health care providers for their costs incurred in providing services pursuant to subsection c. of this section for any 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 contract, policy, or plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223); and (3) for whom the deductible limits of that contract, policy, or plan have not been exceeded.

c. Licensed health care facilities and licensed health care providers shall provide 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 covered under a contract, policy, or plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using

a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223); and (3) for whom the deductible limits of that contract, policy, or plan are not exceeded. Licensed health care facilities and licensed health care providers shall not seek reimbursement for any costs incurred pursuant to this subsection from the insureds covered under a contract, policy, or plan that qualifies as a high deductible health plan for which medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) or the carrier that issued the high deductible health plan for which medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223).

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

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

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

23. a. The Commissioner of Banking and Insurance shall monitor the implementation and effect of P.L.2005, c.248 (C.17:48E-35.27 et al.) on the health insurance marketplace and shall report to the Governor, the Legislature, and the committees as provided in subsection c. of this section, no later than: 12 months after the effective date of this act with an initial report; and 24 months after the effective date of this act with a final report containing the commissioner's findings.

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

c. The Senate Health, Human Services and Senior Citizens Committee and the General Assembly Health and Human Services Committee, or their respective successors, are each charged with monitoring and evaluating the effect of the provisions of P.L.2005, c.248 (C.17:48E-35.27 et al.) on the insurance marketplace. The Commissioner of Banking and Insurance shall, no later than 24 months after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), present the findings of the commissioner's final report prepared pursuant to subsection a. of this section before each committee, which committee meetings shall be open to the public and include public comment periods. The committees shall, upon receiving the final report prepared pursuant to subsection a. of this section, and the testimony of the commissioner and the public provided pursuant to this subsection, issue as it may deem necessary and proper, recommendations for administrative or legislative changes affecting the implementation of P.L.2005, c.248 (C.17:48E-35.27 et al.).

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

Approved December 21, 2005.