26:2-103.1

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 373
NJSA: 26:2-103.1 (Screening of newborns for hearing loss)
BILL NO: S1096 (Substituted for A2642)
SPONSOR(S): Mattheussen and Sinagra
DATE INTRODUCED: March 16, 2000
COMMITTEE: **ASSEMBLY:** Health; Appropriations
SENATE: Health
AMENDED DURING PASSAGE: Yes
DATE OF PASSAGE: **ASSEMBLY** December 17, 2001
SENATE: January 7, 2002
DATE OF APPROVAL: January 8, 2002
FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (2nd reprint enacted)
(Amendments during passage denoted by superscript numbers)

S1096

SPONSORS STATEMENT: (Begins on page 16 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 2-5-2001(Health)
6-4-2001(Appropr.)
SENATE: Yes
FLOOR AMENDMENT STATEMENTS: No
LEGISLATIVE FISCAL NOTE: Yes

A2642

SPONSORS STATEMENT: (Begins on page 17 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 2-5-2001(Health)
6-4-2001(Appropr.)
Identical to Assembly Statements to S1096
SENATE: No
FLOOR AMENDMENT STATEMENTS: No
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Identical to fiscal note for S1096

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SENATE, No. 1096

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 16, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

SYNOPSIS
Mandates universal screening of newborns for hearing loss.

CURRENT VERSION OF TEXT
As introduced.

1 **AN ACT** concerning universal newborn hearing screening,
2 supplementing Title 26 of the Revised Statutes, amending
3 P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing
4 P.L.1977, c.19.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) The Legislature finds and declares that:
10 Hearing loss occurs in newborns more frequently than any other
11 health condition for which newborn screening is currently required.
12 Moreover, early detection of hearing loss in a child and early
13 intervention and treatment before six months of age has been
14 demonstrated to be highly effective in facilitating a child's healthy
15 development in a manner consistent with the child's age and cognitive
16 ability. Eighty percent of a child's ability to learn speech, language and
17 related cognitive skills is established by the time the child is 36 months
18 of age, and hearing is vitally important to the healthy development of
19 such language skills. Due to advances in medical technology, children
20 of all ages can receive reliable and valid screening for hearing loss in
21 a cost-effective manner. Appropriate screening and identification of
22 newborns and infants with hearing loss will facilitate early intervention
23 and treatment in the critical time period for language development, and
24 may, therefore, serve the public purposes of promoting the healthy
25 development of children and reducing public expenditures for health
26 care and special education and related services.
27 Therefore, it is necessary for the Legislature to establish a
28 universal newborn hearing screening program that will: a. provide
29 early detection of hearing loss in newborn children at the hospital or
30 birthing center or as soon after birth as possible; b. enable these
31 children and their care givers to obtain needed multi-disciplinary
32 evaluation, treatment, and intervention services at the earliest
33 opportunity; and c. prevent or mitigate the developmental delays and
34 academic failures associated with late identification of hearing loss.
35
36 2. (New section) As used in this act:
37 "Commissioner" means the Commissioner of Health and Senior
38 Services.
39 "Department" means the Department of Health and Senior Services.
40 "Electrophysiologic screening measures" means the electrical result
41 of the application of physiologic agents and includes, but is not limited
42 to, the procedures currently known as Auditory Brainstem Response
43 testing (ABR) and Otoacoustic Emissions testing (OAE) and any other

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

Matter underlined thus is new matter.

1 procedure adopted by regulation by the commissioner.
2 "Hearing loss" means a hearing loss of 30dB or greater in the
3 frequency region important for speech recognition and comprehension
4 in one or both ears, which is approximately 500 through 4000 Hz.,
5 except that the commissioner may adopt a standard which establishes
6 a less severe hearing loss, as appropriate.
7 "Newborn" means a child up to 28 days old.
8 "Parent" means a biological parent, stepparent, adoptive parent,
9 legal guardian or other legal custodian of a child.
10
11 3. (New section) a. The commissioner shall ensure that, effective
12 January 1, 2001, all newborn children in the State shall be screened
13 for hearing loss by an appropriate eletrophysiologic screening measure.
14 b. Effective January 1, 2001, the department shall issue
15 guidelines for the periodic monitoring of all infants between the age of
16 29 days and 36 months for delayed onset hearing loss.
17 c. Notwithstanding the provisions of subsection a. of this section
18 to the contrary, no newborn child shall be screened for hearing loss
19 if the parent of the newborn objects to such screening on the grounds
20 that the screening conflicts with the parents' bona fide religious tenets
21 or practices.
22
23 4. (New section) Every hospital that provides inpatient maternity
24 services and every birthing center licensed in the State pursuant to
25 P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for
26 newborn screening for hearing loss for all newborns born at the
27 facility. The hospital or birthing center shall file a plan with the
28 department, in a manner and on forms prescribed by the commissioner,
29 detailing how the hospital or birthing center will implement the
30 newborn hearing screening requirements established pursuant to this
31 act. The plan shall include, at a minimum, the following:
32 a. the electrophysiologic screening measure to be performed;
33 b. the qualifications of the personnel designated to perform the
34 electrophysiologic screening measure;
35 c. guidelines for the provision of follow-up services for newborns
36 identified as having or being at risk of developing a hearing loss;
37 d. the educational services to be provided to the parents of
38 newborns identified as having or being at risk for developing a hearing
39 loss; and
40 e. the protocol to be followed to ensure the confidentiality of any
41 patient identifying information furnished to the department for the
42 purposes of the central registry established pursuant to this act.
43
44 5. (New section) In the case of a newborn born outside of a
45 hospital or birthing center who is not transferred to a hospital or
46 birthing center, the physician or midwife, licensed in this State

1 pursuant to Title 45 of the Revised Statutes, caring for the newborn
2 shall be responsible for ensuring that the newborn hearing screening
3 requirements established pursuant to this act are fulfilled before the
4 newborn is 29 days old.
5
6 6. (New section) a. The commissioner shall establish a central
7 registry of newborns identified as having or being at risk of
8 developing a hearing loss. The information in the central registry shall
9 be used for the purposes of compiling statistical information and
10 providing follow-up counseling, intervention and educational services
11 to the parents of the newborns listed in the registry.
12 b. A hospital, birthing center or health care professional who
13 performs testing required by this act shall report the results of such
14 testing when a hearing loss is indicated to the department in a manner
15 and on forms prescribed by the commissioner.
16
17 7. (New section) The Commissioner of Human Services shall
18 ensure that the newborn hearing screening and periodic monitoring of
19 infants for delayed onset hearing loss required pursuant to this act is
20 a covered service under the State Medicaid program established
21 pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.) and the "Children's
22 Health Care Coverage Program," established pursuant to P.L.1997,
23 c.272 (C.30:4I-1 et seq).
24
25 8. (New section) The commissioner shall establish a Hearing
26 Evaluation Council to provide on-going advice to the department on
27 implementation of this act. The council shall be composed of not less
28 than seven persons appointed by the commissioner who include: a
29 board certified pediatrician, a board certified otolaryngologist, an
30 audiologist with certified clinical competence, a person who is
31 profoundly deaf, a person who is hearing impaired, a hearing person
32 of parents who are deaf, and a citizen of the State who is interested in
33 the concerns and welfare of the deaf.
34 Each member shall hold office for a term of two years and until
35 each member's successor is appointed and qualified. Any person
36 appointed to fill a vacancy occurring prior to the expiration of the term
37 for which the person's predecessor was appointed shall be appointed
38 for the remainder of such term.
39 The council shall meet as frequently as the commissioner deems
40 necessary, but not less than once each year. Council members shall
41 receive no compensation but shall be reimbursed for actual expenses
42 incurred in carrying out their duties as members of this council.
43
44 9. The commissioner, pursuant to the "Administrative Procedure
45 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
46 regulations necessary to implement the provisions of this act.

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

1. No health service corporation contract providing hospital or medical expense benefits for groups with greater than 49 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 this act, 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. , c. (C.) (pending before the Legislature as this bill).

The benefits shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

(cf: P.L.1995, c.316, s.1)

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

2. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than 49 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 this act, 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

1 Department of Health and Senior Services pursuant to section 7 of
2 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
3 necessary medical follow-up and treatment for lead poisoned children.
4 b. All childhood immunizations as recommended by the Advisory
5 Committee on Immunization Practices of the United State Public
6 Health Service and the Department of Health and Senior Services
7 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
8 service corporation shall notify its subscribers, in writing, of any
9 change in coverage with respect to childhood immunizations and any
10 related changes in premium. Such notification shall be in a form and
11 manner to be determined by the Commissioner of Banking and
12 Insurance.
13 c. Screening for newborn hearing loss by appropriate
14 electrophysiologic screening measures and periodic monitoring of
15 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
16 (pending before the Legislature as this bill).
17 The benefits shall be provided to the same extent as for any other
18 medical condition under the contract, except that no deductible shall
19 be applied for benefits provided pursuant to this section. This section
20 shall apply to all hospital service corporation contracts in which the
21 hospital service corporation has reserved the right to change the
22 premium.
23 (cf: P.L.1995, c.316, s.2)
24
25 12. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to
26 read as follows:
27 3. No group health insurance policy providing hospital or medical
28 expense benefits for groups with more than 49 persons shall be
29 delivered, issued, executed or renewed in this State, or approved for
30 issuance or renewal in this State by the Commissioner of Banking and
31 Insurance on or after the effective date of this act, unless the policy
32 provides benefits to any named insured or other person covered
33 thereunder for expenses incurred in the following:
34 a. Screening by blood lead measurement for lead poisoning for
35 children, including confirmatory blood lead testing as specified by the
36 Department of Health and Senior Services pursuant to section 7 of
37 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
38 necessary medical follow-up and treatment for lead poisoned children.
39 b. All childhood immunizations as recommended by the Advisory
40 Committee on Immunization Practices of the United States Public
41 Health Service and the Department of Health and Senior Services
42 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
43 insurer shall notify its policyholders, in writing, of any change in
44 coverage with respect to childhood immunizations and any related
45 changes in premium. Such notification shall be in a form and manner
46 to be determined by the Commissioner of Banking and Insurance.

1 c. Screening for newborn hearing loss by appropriate
2 electrophysiologic screening measures and periodic monitoring of
3 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
4 (pending before the Legislature as this bill).
5 The benefits shall be provided to the same extent as for any other
6 medical condition under the policy, except that no deductible shall be
7 applied for benefits provided pursuant to this section. This section
8 shall apply to all group health insurance policies in which the health
9 insurer has reserved the right to change the premium.
10 (cf: P.L.1995, c.316, s.3)
11
12 13. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to read
13 as follows:
14 4. A certificate of authority to establish and operate a health
15 maintenance organization in this State shall not be issued or continued
16 by the Commissioner of Health and Senior Services on or after the
17 effective date of this act unless the health maintenance organization
18 offers health care services to any enrollee which include:
19 a. Screening by blood lead measurement for lead poisoning for
20 children, including confirmatory blood lead testing as specified by the
21 Department of Health and Senior Services pursuant to section 7 of
22 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
23 necessary medical follow-up and treatment for lead poisoned children.
24 b. All childhood immunizations as recommended by the Advisory
25 Committee on Immunization Practices of the United States Public
26 Health Service and the Department of Health and Senior Services
27 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
28 maintenance organization shall notify its enrollees, in writing, of any
29 change in the health care services provided with respect to childhood
30 immunizations and any related changes in premium. Such notification
31 shall be in a form and manner to be determined by the Commissioner
32 of Banking and Insurance.
33 c. Screening for newborn hearing loss by appropriate
34 electrophysiologic screening measures and periodic monitoring of
35 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
36 (pending before the Legislature as this bill).
37 The health care services shall be provided to the same extent as for
38 any other medical condition under the contract, except that no
39 deductible shall be applied for services provided pursuant to this
40 section. This section shall apply to all contracts under which the
41 health maintenance organization has reserved the right to change the
42 schedule of charges for enrollee coverage.
43 (cf: P.L.1995, c.316, s.4)
44
45 14. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
46 read as follows:

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

1 notice and hearing, disapproves their continued use.
2 e. Effective immediately for an individual health benefits plan
3 issued on or after the effective date of P.L.1995, c.316
4 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
5 date of an individual health benefits plan in effect on the effective date
6 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
7 benefits plans required pursuant to section 3 of P.L.1992, c.161
8 (C.17B:27A-4), including any plan offered by a federally qualified
9 health maintenance organization, shall contain benefits for expenses
10 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 immunizations as recommended by the Advisory
17 Committee on Immunization Practices of the United States 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 <u>(3) Screening for newborn hearing loss by appropriate</u>
26 <u>electrophysiologic screening measures and periodic monitoring of</u>
27 <u>infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)</u>
28 <u>(pending before the Legislature as this bill).</u>
29 The benefits shall be provided to the same extent as for any other
30 medical condition under the health benefits plan, except that no
31 deductible shall be applied for benefits provided pursuant to this
32 section. This section shall apply to all individual health benefits plans
33 in which the carrier has reserved the right to change the premium.
34 (cf: P.L.1997, c.414, s.1)
35
36 15. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
37 read as follows:
38 3. a. Except as provided in subsection f. of this section, every
39 small employer carrier shall, as a condition of transacting business in
40 this State, offer to every small employer the five health benefit plans
41 as provided in this section. The board shall establish a standard policy
42 form for each of the five plans, which except as otherwise provided in
43 subsection j. of this section, shall be the only plans offered to small
44 groups on or after January 1, 1994. One policy form shall contain the
45 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
46 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity

1 carriers, one policy form shall be established which contains benefits
2 and cost sharing levels which are equivalent to the health benefits
3 plans of health maintenance organizations pursuant to the "Health
4 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
5 s.300e et seq.). The remaining policy forms shall contain basic hospital
6 and medical-surgical benefits, including, but not limited to:
7 (1) Basic inpatient and outpatient hospital care;
8 (2) Basic and extended medical-surgical benefits;
9 (3) Diagnostic tests, including X-rays;
10 (4) Maternity benefits, including prenatal and postnatal care; and
11 (5) Preventive medicine, including periodic physical examinations
12 and inoculations.
13 At least three of the forms shall provide for major medical benefits
14 in varying lifetime aggregates, one of which shall provide at least
15 $1,000,000 in lifetime aggregate benefits. The policy forms provided
16 pursuant to this section shall contain benefits representing
17 progressively greater actuarial values.
18 Notwithstanding the provisions of this subsection to the contrary,
19 the board also may establish additional policy forms by which a small
20 employer carrier, other than a health maintenance organization, may
21 provide indemnity benefits for health maintenance organization
22 enrollees by direct contract with the enrollees' small employer through
23 a dual arrangement with the health maintenance organization. The
24 dual arrangement shall be filed with the commissioner for approval.
25 The additional policy forms shall be consistent with the general
26 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).
27 b. Initially, a carrier shall offer a plan within 90 days of the
28 approval of such plan by the commissioner. Thereafter, the plans shall
29 be available to all small employers on a continuing basis. Every small
30 employer which elects to be covered under any health benefits plan
31 who pays the premium therefor and who satisfies the participation
32 requirements of the plan shall be issued a policy or contract by the
33 carrier.
34 c. The carrier may establish a premium payment plan which
35 provides installment payments and which may contain reasonable
36 provisions to ensure payment security, provided that provisions to
37 ensure payment security are uniformly applied.
38 d. In addition to the five standard policies described in subsection
39 a. of this section, the board may develop up to five rider packages.
40 Any such package which a carrier chooses to offer shall be issued to
41 a small employer who pays the premium therefor, and shall be subject
42 to the rating methodology set forth in section 9 of P.L.1992, c.162
43 (C.17B:27A-25).
44 e. Notwithstanding the provisions of subsection a. of this section
45 to the contrary, the board may approve a health benefits plan
46 containing only medical-surgical benefits or major medical expense

1 benefits, or a combination thereof, which is issued as a separate policy
2 in conjunction with a contract of insurance for hospital expense
3 benefits issued by a hospital service corporation, if the health benefits
4 plan and hospital service corporation contract combined otherwise
5 comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et
6 seq.). Deductibles and coinsurance limits for the contract combined
7 may be allocated between the separate contracts at the discretion of
8 the carrier and the hospital service corporation.
9 f. Notwithstanding the provisions of this section to the contrary,
10 a health maintenance organization which is a qualified health
11 maintenance organization pursuant to the "Health Maintenance
12 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)
13 shall be permitted to offer health benefits plans formulated by the
14 board and approved by the commissioner which are in accordance with
15 the provisions of that law in lieu of the five plans required pursuant to
16 this section.
17 Notwithstanding the provisions of this section to the contrary, a
18 health maintenance organization which is approved pursuant to
19 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
20 benefits plans formulated by the board and approved by the
21 commissioner which are in accordance with the provisions of that law
22 in lieu of the five plans required pursuant to this section, except that
23 the plans shall provide the same level of benefits as required for a
24 federally qualified health maintenance organization, including any
25 requirements concerning copayments by enrollees.
26 g. A carrier shall not be required to own or control a health
27 maintenance organization or otherwise affiliate with a health
28 maintenance organization in order to comply with the provisions of
29 this section, but the carrier shall be required to offer the five health
30 benefits plans which are formulated by the board and approved by the
31 commissioner, including one plan which contains benefits and cost
32 sharing levels that are equivalent to those required for health
33 maintenance organizations.
34 h. Notwithstanding the provisions of subsection a. of this section
35 to the contrary, the board may modify the benefits provided for in
36 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2
37 and 26:2J-4.3).
38 i. (1) In addition to the rider packages provided for in subsection d.
39 of this section, every carrier may offer, in connection with the five
40 health benefits plans required to be offered by this section, any number
41 of riders which may revise the coverage offered by the five plans in
42 any way, provided, however, that any form of such rider or
43 amendment thereof which decreases benefits or decreases the actuarial
44 value of one of the five plans shall be filed for informational purposes
45 with the board and for approval by the commissioner before such rider
46 may be sold. Any rider or amendment thereof which adds benefits or

1 increases the actuarial value of one of the five plans shall be filed with
2 the board for informational purposes before such rider may be sold.
3 The commissioner shall disapprove any rider filed pursuant to this
4 subsection that is unjust, unfair, inequitable, unreasonably
5 discriminatory, misleading, contrary to law or the public policy of this
6 State. The commissioner shall not approve any rider which reduces
7 benefits below those required by sections 55, 57 and 59 of P.L.1991,
8 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be
9 sold pursuant to this section. The commissioner's determination shall
10 be in writing and shall be appealable.
11 (2) The benefit riders provided for in paragraph (1) of this
12 subsection shall be subject to the provisions of section 2, subsection
13 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
14 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23,
15 17B:27A-24, 17B:27A-25, and 17B:27A-27).
16 j. (1) Notwithstanding the provisions of P.L.1992, c.162
17 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
18 by or through a carrier, association, multiple employer arrangement
19 prior to January 1, 1994 or, if the requirements of subparagraph (c) of
20 paragraph (6) of this subsection are met, issued by or through an
21 out-of-State trust prior to January 1, 1994, at the option of a small
22 employer policy or contract holder, may be renewed or continued after
23 February 28, 1994, or in the case of such a health benefits plan whose
24 anniversary date occurred between March 1, 1994 and the effective
25 date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated
26 within 60 days of that anniversary date and renewed or continued if,
27 beginning on the first 12-month anniversary date occurring on or after
28 the sixtieth day after the board adopts regulations concerning the
29 implementation of the rating factors permitted by section 9 of
30 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
31 delivery of the health benefits plan, the health benefits plan renewed,
32 continued or reinstated pursuant to this subsection complies with the
33 provisions of section 2, subsection b. of section 3, and sections 6, 7,
34 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
35 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
36 17B:27A-27) and section 7 of P.L.1995, c.340 **[**(C.17B:27A-19.3)**]**
37 (C.17B:27A-19.3).
38 Nothing in this subsection shall be construed to require an
39 association, multiple employer arrangement or out-of-State trust to
40 provide health benefits coverage to small employers that are not
41 contemplated by the organizational documents, bylaws, or other
42 regulations governing the purpose and operation of the association,
43 multiple employer arrangement or out-of-State trust. Notwithstanding
44 the foregoing provision to the contrary, an association, multiple
45 employer arrangement or out-of-State trust that offers health benefits
46 coverage to its members' employees and dependents:

1 (a) shall offer coverage to all eligible employees and their
2 dependents within the membership of the association, multiple
3 employer arrangement or out-of-State trust;
4 (b) shall not use actual or expected health status in determining its
5 membership; and
6 (c) shall make available to its small employer members at least one
7 of the standard benefits plans, as determined by the commissioner, in
8 addition to any health benefits plan permitted to be renewed or
9 continued pursuant to this subsection.
10 (2) Notwithstanding the provisions of this subsection to the
11 contrary, a carrier or out-of-State trust which writes the health
12 benefits plans required pursuant to subsection a. of this section shall
13 be required to offer those plans to any small employer, association or
14 multiple employer arrangement.
15 (3) (a) A carrier, association, multiple employer arrangement or
16 out-of-State trust may withdraw a health benefits plan marketed to
17 small employers that was in effect on December 31, 1993 with the
18 approval of the commissioner. The commissioner shall approve a
19 request to withdraw a plan, consistent with regulations adopted by the
20 commissioner, only on the grounds that retention of the plan would
21 cause an unreasonable financial [burder]<u>burden</u> to the issuing carrier,
22 taking into account the rating provisions of section 9 of P.L.1992,
23 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
24 (C.17B:27A-19.3).
25 (b) A carrier which has renewed, continued or reinstated a health
26 benefits plan pursuant to this subsection that has not been newly issued
27 to a new small employer group since January 1, 1994, may, upon
28 approval of the commissioner, continue to establish its rates for that
29 plan based on the loss experience of that plan if the carrier does not
30 issue that health benefits plan to any new small employer groups.
31 (4) (Deleted by amendment, P.L.1995, c.340).
32 (5) A health benefits plan that otherwise conforms to the
33 requirements of this subsection shall be deemed to be in compliance
34 with this subsection, notwithstanding any change in the plan's
35 deductible or copayment.
36 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
37 of this paragraph, a health benefits plan renewed, continued or
38 reinstated pursuant to this subsection shall be filed with the
39 commissioner for informational purposes within 30 days after its
40 renewal date. No later than 60 days after the board adopts regulations
41 concerning the implementation of the rating factors permitted by
42 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
43 amended to show any modifications in the plan that are necessary to
44 comply with the provisions of this subsection. The commissioner shall
45 monitor compliance of any such plan with the requirements of this
46 subsection, except that the board shall enforce the loss ratio

1 requirements.
2 (b) A health benefits plan filed with the commissioner pursuant to
3 subparagraph (a) of this paragraph may be amended as to its benefit
4 structure if the amendment does not reduce the actuarial value and
5 benefits coverage of the health benefits plan below that of the lowest
6 standard health benefits plan established by the board pursuant to
7 subsection a. of this section. The amendment shall be filed with the
8 commissioner for approval pursuant to the terms of sections 4, 8, 12
9 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
10 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
11 shall comply with the provisions of sections 2 and 9 of P.L.1992,
12 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
13 c.340 (C.17B:27A-19.3).
14 (c) A health benefits plan issued by a carrier through an
15 out-of-State trust shall be permitted to be renewed or continued
16 pursuant to paragraph (1) of this subsection upon approval by the
17 commissioner and only if the benefits offered under the plan are at
18 least equal to the actuarial value and benefits coverage of the lowest
19 standard health benefits plan established by the board pursuant to
20 subsection a. of this section. For the purposes of meeting the
21 requirements of this subparagraph, carriers shall be required to file
22 with the commissioner the health benefits plans issued through an
23 out-of-State trust no later than 180 days after the date of enactment
24 of P.L.1995, c.340. A health benefits plan issued by a carrier through
25 an out-of-State trust that is not filed with the commissioner pursuant
26 to this subparagraph, shall not be permitted to be continued or
27 renewed after the 180-day period.
28 (7) Notwithstanding the provisions of P.L.1992, c.162
29 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
30 employer arrangement or out-of-State trust may offer a health benefits
31 plan authorized to be renewed, continued or reinstated pursuant to this
32 subsection to small employer groups that are otherwise eligible
33 pursuant to paragraph (1) of subsection j. of this section during the
34 period for which such health benefits plan is otherwise authorized to
35 be renewed, continued or reinstated.
36 (8) Notwithstanding the provisions of P.L.1992, c.162
37 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
38 employer arrangement or out-of-State trust may offer coverage under
39 a health benefits plan authorized to be renewed, continued or
40 reinstated pursuant to this subsection to new employees of small
41 employer groups covered by the health benefits plan in accordance
42 with the provisions of paragraph (1) of this subsection.
43 (9) Notwithstanding the provisions of P.L.1992, c.162
44 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
45 the contrary, any individual, who is eligible for small employer
46 coverage under a policy issued, renewed, continued or reinstated

1 pursuant to this subsection, but who would be subject to a preexisting
2 condition exclusion under the small employer health benefits plan, or
3 who is a member of a small employer group who has been denied
4 coverage under the small employer group health benefits plan for
5 health reasons, may elect to purchase or continue coverage under an
6 individual health benefits plan until such time as the group health
7 benefits plan covering the small employer group of which the
8 individual is a member complies with the provisions of P.L.1992, c.162
9 (C.17B:27A-17 et seq.).
10 (10) In a case in which an association made available a health
11 benefits plan on or before March 1, 1994 and subsequently changed
12 the issuing carrier between March 1, 1994 and the effective date of
13 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
14 eligible to continue and renew the plan pursuant to paragraph (1) of
15 this subsection.
16 (11) In a case in which an association, multiple employer
17 arrangement or out-of-State trust made available a health benefits plan
18 on or before March 1, 1994 and subsequently changes the issuing
19 carrier for that plan after the effective date of P.L.1995, c.340, the
20 new issuing carrier shall file the health benefits plan with the
21 commissioner for approval in order to be deemed eligible to continue
22 and renew that plan pursuant to paragraph (1) of this subsection.
23 (12) In a case in which a small employer purchased a health benefits
24 plan directly from a carrier on or before March 1, 1994 and
25 subsequently changes the issuing carrier for that plan after the
26 effective date of P.L.1995, c.340, the new issuing carrier shall file the
27 health benefits plan with the commissioner for approval in order to be
28 deemed eligible to continue and renew that plan pursuant to paragraph
29 (1) of this subsection.
30 Notwithstanding the provisions of subparagraph (b) of paragraph
31 (6) of this subsection to the contrary, a small employer who changes
32 its health benefits plan's issuing carrier pursuant to the provisions of
33 this paragraph, shall not, upon changing carriers, modify the benefit
34 structure of that health benefits plan within six months of the date the
35 issuing carrier was changed.
36 k. Effective immediately for a health benefits plan issued on or
37 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and
38 effective on the first 12-month anniversary date of a health benefits
39 plan in effect on the effective date of P.L.1995, c.316
40 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to
41 this section, including any plans offered by a State approved or
42 federally qualified health maintenance organization, shall contain
43 benefits for expenses 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

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. , c. (C.) (pending before the Legislature as this bill).

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this section. This section 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.

(cf: P.L.1997, c.419, s.6)

16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.

17. This act shall take effect on the 180th day after enactment, but the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act. The universal newborn hearing screening requirements of sections 10 through 15 of this act shall apply to all policies, contracts and health benefits plans issued or renewed on or after the effective date of this act.

STATEMENT

Hearing loss occurs in newborns more frequently than any other health condition for which newborn screening is currently required and advances in medical technology have made it possible for children of all ages to be able to receive reliable and valid screening in a cost-effective manner. Accordingly, this bill mandates that all newborn

children in the State be screened for hearing loss, provides for the periodic monitoring of all infants for delayed onset hearing loss and mandates that health insurance plans as well as the State Medicaid and NJ KidCare programs provide coverage for this testing and monitoring.

This mandatory universal newborn hearing screening program is needed because early detection of hearing loss in a child and early intervention and treatment before six months of age has been demonstrated to be highly effective in facilitating a child's healthy cognitive and language development. Furthermore, early detection and intervention will not only promote the healthy development of children but also may reduce public expenditures for health care and special education and related services.

Currently, the laws of this State do not require that newborns be tested for hearing loss. Rather, each newborn is screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child.

This bill requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2001, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. Likewise, the bill provides that the Department of Health and Senior Services establish guidelines, to be effective January 1, 2001, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and licensed birthing centers to provide newborn screening for hearing loss for all newborns born at their facility. The bill also requires hospitals and birthing centers to report to the Department of Health and Senior Services how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

- the electrophysiologic screening measure to be used;
- the qualifications of the personnel designated to perform the electrophysiologic screening measure;
- the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;
- the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and

C the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill requires that the licensed physician or midwife who is caring for the newborn ensure that the newborn is screened for hearing loss before the newborn is 29 days old.

The bill also directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19, to provide on-going advice to the department of the implementation of a universal newborn hearing screening program in this State. The members will be appointed by the commission and will include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member will hold office for a term of two years.

Finally, this bill repeals P.L.1977, c.19 (C.26:2-101 et seq.), which established the current newborn hearing screening program, since the universal newborn hearing screening program in this bill will replace the current program.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 1096

with committe amendments

STATE OF NEW JERSEY

DATED: MAY 11, 2000

The Senate Health Committee reports favorably and with committee amendments Senate Bill No. 1096.

Provisions of the Bill:

As amended by committee, the bill requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2001, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. Likewise, the bill provides that the Department of Health and Senior Services establish guidelines, to be effective January 1, 2001, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facility. The bill also requires hospitals and birthing centers to report to the Department of Health and Senior Services how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

C the electrophysiologic screening measure to be used;

C the qualifications of the personnel designated to perform the electrophysiologic screening measure;

C the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;

C the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and

C the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill

requires that the physician or midwife who is caring for the newborn ensure that the newborn is screened for hearing loss before the newborn is 29 days old.

The bill also directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19, to provide on-going advice to the department on the implementation of a universal newborn hearing screening program in this State. The members will be appointed by the commission and will include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member will hold office for a term of two years.

The bill mandates that health, hospital and medical service corporations, individual, small employer and group health insurers, health maintenance organizations, and the State Medicaid and NJ KidCare programs provide third party coverage for the newborn testing and monitoring. Also, consistent with the insurance mandates for screening for childhood lead poisoning and childhood immunizations enacted in 1995, the bill provides that no deductible shall be applied to the newborn hearing insurance benefit.

Finally, this bill repeals P.L.1977, c.19 (C.26:2-101 et seq.), which established the current newborn hearing screening program, since the universal newborn hearing screening program in this bill will replace the current program.

The bill takes effect 180 days after enactment.

Committee amendments:

The committee amended the bill to specify that payment for the screening service by health insurance carriers shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee negotiated with the provider and facility. The committee also adopted a technical amendment to sections 10, 11 and 12 of the bill to conform references to small employer health benefits plans to current law, that is, that the maximum number of employees under such a plan is 50, rather than 49 as those sections currently provide.

For Your Information:

Currently, State law, N.J.S.A.26:2-101 et seq., does not require that newborns be tested for hearing loss. Rather, each newborn is

screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child. This bill repeals current law because the universal newborn hearing screening program in this bill will replace the current program.

According to the National Conference of State Legislatures, at least 23 states have enacted laws mandating universal or nearly universal hearing testing of newborns, and at least nine states mandate health insurance coverage for the testing.

[First Reprint]

SENATE, No. 1096

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 16, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

SYNOPSIS

Mandates universal screening of newborns for hearing loss.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee on May 11, 2000, with amendments.

1 **AN ACT** concerning universal newborn hearing screening,
2 supplementing Title 26 of the Revised Statutes, amending
3 P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing
4 P.L.1977, c.19.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) The Legislature finds and declares that:
10 Hearing loss occurs in newborns more frequently than any other
11 health condition for which newborn screening is currently required.
12 Moreover, early detection of hearing loss in a child and early
13 intervention and treatment before six months of age has been
14 demonstrated to be highly effective in facilitating a child's healthy
15 development in a manner consistent with the child's age and cognitive
16 ability. Eighty percent of a child's ability to learn speech, language and
17 related cognitive skills is established by the time the child is 36 months
18 of age, and hearing is vitally important to the healthy development of
19 such language skills. Due to advances in medical technology, children
20 of all ages can receive reliable and valid screening for hearing loss in
21 a cost-effective manner. Appropriate screening and identification of
22 newborns and infants with hearing loss will facilitate early intervention
23 and treatment in the critical time period for language development, and
24 may, therefore, serve the public purposes of promoting the healthy
25 development of children and reducing public expenditures for health
26 care and special education and related services.
27 Therefore, it is necessary for the Legislature to establish a
28 universal newborn hearing screening program that will: a. provide
29 early detection of hearing loss in newborn children at the hospital or
30 birthing center or as soon after birth as possible; b. enable these
31 children and their care givers to obtain needed multi-disciplinary
32 evaluation, treatment, and intervention services at the earliest
33 opportunity; and c. prevent or mitigate the developmental delays and
34 academic failures associated with late identification of hearing loss.
35
36 2. (New section) As used in this act:
37 "Commissioner" means the Commissioner of Health and Senior
38 Services.
39 "Department" means the Department of Health and Senior Services.
40 "Electrophysiologic screening measures" means the electrical result
41 of the application of physiologic agents and includes, but is not limited
42 to, the procedures currently known as Auditory Brainstem Response

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted May 11, 2000.

1 testing (ABR) and Otoacoustic Emissions testing (OAE) and any other
2 procedure adopted by regulation by the commissioner.
3 "Hearing loss" means a hearing loss of 30dB or greater in the
4 frequency region important for speech recognition and comprehension
5 in one or both ears, which is approximately 500 through 4000 Hz.,
6 except that the commissioner may adopt a standard which establishes
7 a less severe hearing loss, as appropriate.
8 "Newborn" means a child up to 28 days old.
9 "Parent" means a biological parent, stepparent, adoptive parent,
10 legal guardian or other legal custodian of a child.
11
12 3. (New section) a. The commissioner shall ensure that, effective
13 January 1, 2001, all newborn children in the State shall be screened
14 for hearing loss by an appropriate eletrophysiologic screening measure.
15 b. Effective January 1, 2001, the department shall issue guidelines
16 for the periodic monitoring of all infants between the age of 29 days
17 and 36 months for delayed onset hearing loss.
18 c. Notwithstanding the provisions of subsection a. of this section
19 to the contrary, no newborn child shall be screened for hearing loss
20 if the parent of the newborn objects to such screening on the grounds
21 that the screening conflicts with the parents' bona fide religious tenets
22 or practices.
23
24 4. (New section) Every hospital that provides inpatient maternity
25 services and every birthing center licensed in the State pursuant to
26 P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for
27 newborn screening for hearing loss for all newborns born at the
28 facility. The hospital or birthing center shall file a plan with the
29 department, in a manner and on forms prescribed by the commissioner,
30 detailing how the hospital or birthing center will implement the
31 newborn hearing screening requirements established pursuant to this
32 act. The plan shall include, at a minimum, the following:
33 a. the electrophysiologic screening measure to be performed;
34 b. the qualifications of the personnel designated to perform the
35 electrophysiologic screening measure;
36 c. guidelines for the provision of follow-up services for newborns
37 identified as having or being at risk of developing a hearing loss;
38 d. the educational services to be provided to the parents of
39 newborns identified as having or being at risk for developing a hearing
40 loss; and
41 e. the protocol to be followed to ensure the confidentiality of any
42 patient identifying information furnished to the department for the
43 purposes of the central registry established pursuant to this act.
44
45 5. (New section) In the case of a newborn born outside of a
46 hospital or birthing center who is not transferred to a hospital or

1 birthing center, the physician or midwife, licensed in this State
2 pursuant to Title 45 of the Revised Statutes, caring for the newborn
3 shall be responsible for ensuring that the newborn hearing screening
4 requirements established pursuant to this act are fulfilled before the
5 newborn is 29 days old.
6
7 6. (New section) a. The commissioner shall establish a central
8 registry of newborns identified as having or being at risk of
9 developing a hearing loss. The information in the central registry shall
10 be used for the purposes of compiling statistical information and
11 providing follow-up counseling, intervention and educational services
12 to the parents of the newborns listed in the registry.
13 b. A hospital, birthing center or health care professional who
14 performs testing required by this act shall report the results of such
15 testing when a hearing loss is indicated to the department in a manner
16 and on forms prescribed by the commissioner.
17
18 7. (New section) The Commissioner of Human Services shall
19 ensure that the newborn hearing screening and periodic monitoring of
20 infants for delayed onset hearing loss required pursuant to this act is
21 a covered service under the State Medicaid program established
22 pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.) and the "Children's
23 Health Care Coverage Program," established pursuant to P.L.1997,
24 c.272 (C.30:4I-1 et seq).
25
26 8. (New section) The commissioner shall establish a Hearing
27 Evaluation Council to provide on-going advice to the department on
28 implementation of this act. The council shall be composed of not less
29 than seven persons appointed by the commissioner who include: a
30 board certified pediatrician, a board certified otolaryngologist, an
31 audiologist with certified clinical competence, a person who is
32 profoundly deaf, a person who is hearing impaired, a hearing person
33 of parents who are deaf, and a citizen of the State who is interested in
34 the concerns and welfare of the deaf.
35 Each member shall hold office for a term of two years and until
36 each member's successor is appointed and qualified. Any person
37 appointed to fill a vacancy occurring prior to the expiration of the term
38 for which the person's predecessor was appointed shall be appointed
39 for the remainder of such term.
40 The council shall meet as frequently as the commissioner deems
41 necessary, but not less than once each year. Council members shall
42 receive no compensation but shall be reimbursed for actual expenses
43 incurred in carrying out their duties as members of this council.
44
45 9. The commissioner, pursuant to the "Administrative Procedure
46 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and

1 regulations necessary to implement the provisions of this act.
2
3 10. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
4 read as follows:
5 1. No health service corporation contract providing hospital or
6 medical expense benefits for groups with greater than [1][49] 50[1]
7 persons shall be delivered, issued, executed or renewed in this State,
8 or approved for issuance or renewal in this State by the Commissioner
9 of Banking and Insurance on or after the effective date of this act,
10 unless the contract provides benefits to any named subscriber or other
11 person covered thereunder for expenses incurred in the following:
12 a. Screening by blood lead measurement for lead poisoning for
13 children, including confirmatory blood lead testing as specified by the
14 Department of Health and Senior Services pursuant to section 7 of
15 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
16 necessary medical follow-up and treatment for lead poisoned children.
17 b. All childhood immunizations as recommended by the Advisory
18 Committee on Immunization Practices of the United States Public
19 Health Service and the Department of Health and Senior Services
20 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
21 service corporation shall notify its subscribers, in writing, of any
22 change in coverage with respect to childhood immunizations and any
23 related changes in premium. Such notification shall be in a form and
24 manner to be determined by the Commissioner of Banking and
25 Insurance.
26 c. Screening for newborn hearing loss by appropriate
27 electrophysiologic screening measures and periodic monitoring of
28 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
29 (pending before the Legislature as this bill).[1]Payment for this screening
30 service shall be separate and distinct from payment for routine new
31 baby care in the form of a newborn hearing screening fee as negotiated
32 with the provider and facility.[1]
33 The benefits shall be provided to the same extent as for any other
34 medical condition under the contract, except that no deductible shall
35 be applied for benefits provided pursuant to this section. This section
36 shall apply to all health service corporation contracts in which the
37 health service corporation has reserved the right to change the
38 premium.
39 (cf: P.L.1995, c.316, s.1)
40
41 11. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
42 as follows:
43 2. No hospital service corporation contract providing hospital or
44 medical expense benefits for groups with greater than [1][49] 50[1]
45 persons shall be delivered, issued, executed or renewed in this State,
46 or approved for issuance or renewal in this State by the Commissioner

1 of Banking and Insurance on or after the effective date of this act,
2 unless the contract provides benefits to any named subscriber or other
3 person covered thereunder for expenses incurred in the following:
4 a. Screening by blood lead measurement for lead poisoning for
5 children, including confirmatory blood lead testing as specified by the
6 Department of Health and Senior Services pursuant to section 7 of
7 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
8 necessary medical follow-up and treatment for lead poisoned children.
9 b. All childhood immunizations as recommended by the Advisory
10 Committee on Immunization Practices of the United State Public
11 Health Service and the Department of Health and Senior Services
12 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
13 service corporation shall notify its subscribers, in writing, of any
14 change in coverage with respect to childhood immunizations and any
15 related changes in premium. Such notification shall be in a form and
16 manner to be determined by the Commissioner of Banking and
17 Insurance.
18 c. Screening for newborn hearing loss by appropriate
19 electrophysiologic screening measures and periodic monitoring of
20 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
21 (pending before the Legislature as this bill).[1]Payment for this screening
22 service shall be separate and distinct from payment for routine new
23 baby care in the form of a newborn hearing screening fee as negotiated
24 with the provider and facility.[1]
25 The benefits shall be provided to the same extent as for any other
26 medical condition under the contract, except that no deductible shall
27 be applied for benefits provided pursuant to this section. This section
28 shall apply to all hospital service corporation contracts in which the
29 hospital service corporation has reserved the right to change the
30 premium.
31 (cf: P.L.1995, c.316, s.2)
32
33 12. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to
34 read as follows:
35 3. No group health insurance policy providing hospital or medical
36 expense benefits for groups with more than [1]**[**49**]** 50[1] persons shall be
37 delivered, issued, executed or renewed in this State, or approved for
38 issuance or renewal in this State by the Commissioner of Banking and
39 Insurance on or after the effective date of this act, unless the policy
40 provides benefits to any named insured or other person covered
41 thereunder for expenses incurred in the following:
42 a. Screening by blood lead measurement for lead poisoning for
43 children, including confirmatory blood lead testing as specified by the
44 Department of Health and Senior Services pursuant to section 7 of
45 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
46 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. , c. (C.) (pending before the Legislature as this bill).[1]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.[1]

The benefits shall be provided to the same extent as for any other medical condition under the policy, except that no deductible shall 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.

(cf: P.L.1995, c.316, s.3)

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

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 this act 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. , c. (C.)

1 (pending before the Legislature as this bill).[1]Payment for this screening
2 service shall be separate and distinct from payment for routine new
3 baby care in the form of a newborn hearing screening fee as negotiated
4 with the provider and facility.[1]
5 The health care services shall be provided to the same extent as for
6 any other medical condition under the contract, except that no
7 deductible shall be applied for services provided pursuant to this
8 section. This section shall apply to all contracts under which the
9 health maintenance organization has reserved the right to change the
10 schedule of charges for enrollee coverage.
11 (cf: P.L.1995, c.316, s.4)
12
13 14. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
14 read as follows:
15 6. The board shall establish the policy and contract forms and
16 benefit levels to be made available by all carriers for the health benefits
17 plans required to be issued pursuant to section 3 of P.L.1992, c.161
18 (C.17B:27A-4), and shall adopt such modifications to one or more
19 plans as the board determines are necessary to make available a "high
20 deductible health plan" or plans consistent with section 301 of Title III
21 of the "Health Insurance Portability and Accountability Act of 1996,"
22 Pub.L.104-191, regarding tax-deductible medical savings accounts,
23 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
24 al.). The board shall provide the commissioner with an informational
25 filing of the policy and contract forms and benefit levels it establishes.
26 a. The individual health benefits plans established by the board
27 may include cost containment measures such as, but not limited to:
28 utilization review of health care services, including review of medical
29 necessity of hospital and physician services; case management benefit
30 alternatives; selective contracting with hospitals, physicians, and other
31 health care providers; and reasonable benefit differentials applicable to
32 participating and nonparticipating providers; and other managed care
33 provisions.
34 b. An individual health benefits plan offered pursuant to section 3
35 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
36 more than 12 months on coverage for preexisting conditions. An
37 individual health benefits plan offered pursuant to section 3 of
38 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
39 condition limitation of any period under the following circumstances:
40 (1) to an individual who has, under creditable coverage, with no
41 intervening lapse in coverage of more than 31 days, been treated or
42 diagnosed by a physician for a condition under that plan or satisfied a
43 12-month preexisting condition limitation; or
44 (2) to a federally defined eligible individual who applies for an
45 individual health benefits plan within 63 days of termination of the
46 prior coverage.

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

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

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

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

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

(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. , c. (C.) (pending before the Legislature as this bill).[1]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.[1]

The benefits shall be provided to the same extent as for any other

1 medical condition under the health benefits plan, except that no
2 deductible shall be applied for benefits provided pursuant to this
3 section. This section shall apply to all individual health benefits plans
4 in which the carrier has reserved the right to change the premium.
5 (cf: P.L.1997, c.414, s.1)
6
7 15. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
8 read as follows:
9 3. a. Except as provided in subsection f. of this section, every
10 small employer carrier shall, as a condition of transacting business in
11 this State, offer to every small employer the five health benefit plans
12 as provided in this section. The board shall establish a standard policy
13 form for each of the five plans, which except as otherwise provided in
14 subsection j. of this section, shall be the only plans offered to small
15 groups on or after January 1, 1994. One policy form shall contain the
16 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
17 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
18 carriers, one policy form shall be established which contains benefits
19 and cost sharing levels which are equivalent to the health benefits
20 plans of health maintenance organizations pursuant to the "Health
21 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
22 s.300e et seq.). The remaining policy forms shall contain basic hospital
23 and medical-surgical benefits, including, but not limited to:
24 (1) Basic inpatient and outpatient hospital care;
25 (2) Basic and extended medical-surgical benefits;
26 (3) Diagnostic tests, including X-rays;
27 (4) Maternity benefits, including prenatal and postnatal care; and
28 (5) Preventive medicine, including periodic physical examinations
29 and inoculations.
30 At least three of the forms shall provide for major medical benefits
31 in varying lifetime aggregates, one of which shall provide at least
32 $1,000,000 in lifetime aggregate benefits. The policy forms provided
33 pursuant to this section shall contain benefits representing
34 progressively greater actuarial values.
35 Notwithstanding the provisions of this subsection to the contrary,
36 the board also may establish additional policy forms by which a small
37 employer carrier, other than a health maintenance organization, may
38 provide indemnity benefits for health maintenance organization
39 enrollees by direct contract with the enrollees' small employer through
40 a dual arrangement with the health maintenance organization. The
41 dual arrangement shall be filed with the commissioner for approval.
42 The additional policy forms shall be consistent with the general
43 requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).
44 b. Initially, a carrier shall offer a plan within 90 days of the
45 approval of such plan by the commissioner. Thereafter, the plans shall
46 be available to all small employers on a continuing basis. Every small

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

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

1 P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of
2 delivery of the health benefits plan, the health benefits plan renewed,
3 continued or reinstated pursuant to this subsection complies with the
4 provisions of section 2, subsection b. of section 3, and sections 6, 7,
5 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
6 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
7 17B:27A-27) and section 7 of P.L.1995, c.340 [(C.17B:27A-19.3]
8 (C.17B:27A-19.3).
9 Nothing in this subsection shall be construed to require an
10 association, multiple employer arrangement or out-of-State trust to
11 provide health benefits coverage to small employers that are not
12 contemplated by the organizational documents, bylaws, or other
13 regulations governing the purpose and operation of the association,
14 multiple employer arrangement or out-of-State trust. Notwithstanding
15 the foregoing provision to the contrary, an association, multiple
16 employer arrangement or out-of-State trust that offers health benefits
17 coverage to its members' employees and dependents:
18 (a) shall offer coverage to all eligible employees and their
19 dependents within the membership of the association, multiple
20 employer arrangement or out-of-State trust;
21 (b) shall not use actual or expected health status in determining its
22 membership; and
23 (c) shall make available to its small employer members at least one
24 of the standard benefits plans, as determined by the commissioner, in
25 addition to any health benefits plan permitted to be renewed or
26 continued pursuant to this subsection.
27 (2) Notwithstanding the provisions of this subsection to the
28 contrary, a carrier or out-of-State trust which writes the health
29 benefits plans required pursuant to subsection a. of this section shall
30 be required to offer those plans to any small employer, association or
31 multiple employer arrangement.
32 (3) (a) A carrier, association, multiple employer arrangement or
33 out-of-State trust may withdraw a health benefits plan marketed to
34 small employers that was in effect on December 31, 1993 with the
35 approval of the commissioner. The commissioner shall approve a
36 request to withdraw a plan, consistent with regulations adopted by the
37 commissioner, only on the grounds that retention of the plan would
38 cause an unreasonable financial [burder]burden to the issuing carrier,
39 taking into account the rating provisions of section 9 of P.L.1992,
40 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
41 (C.17B:27A-19.3).
42 (b) A carrier which has renewed, continued or reinstated a health
43 benefits plan pursuant to this subsection that has not been newly issued
44 to a new small employer group since January 1, 1994, may, upon
45 approval of the commissioner, continue to establish its rates for that
46 plan based on the loss experience of that plan if the carrier does not

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

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

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

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

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

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

(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. , c. (C.) (pending before the Legislature as this bill).[1]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.[1]

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this section. This section 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

1 riders to be developed under this section.
2 (cf: P.L.1997, c.419, s.6)
3
4 16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.
5
6 17. This act shall take effect on the 180th day after enactment, but
7 the commissioner may take such anticipatory administrative action in
8 advance as shall be necessary for the implementation of the act. The
9 universal newborn hearing screening requirements of sections 10
10 through 15 of this act shall apply to all policies, contracts and health
11 benefits plans issued or renewed on or after the effective date of this
12 act.

FISCAL NOTE

[First Reprint]

SENATE, No. 1096

STATE OF NEW JERSEY

209th LEGISLATURE

DATED: AUGUST 11, 2000

SUMMARY

Synopsis: Mandates universal screening of newborns for hearing loss.

Type of Impact: Possible increase in State expenditures.

Agencies Affected: Department of Health and Senior Services (DHSS).

Executive Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost	$211,000	$190,000	$179,000

! The Office of Legislative Services (OLS) concurs with the department's estimates.

! The Department of Health and Senior Services (DHSS) currently monitors and tracks children at "high risk" for hearing loss and those who failed an initial electrophysiological screening test. This bill would require that all children in the state be screened for hearing loss.

BILL DESCRIPTION

Senate Bill No. 1096 (1R) of 2000 requires DHSS to ensure that, effective January 1, 2001, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. By January 1, 2001, DHSS would also be required to establish guidelines for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss.

Senate Bill No. 1096 (1R) also imposes:

C various administrative requirements on DHSS with respect to implementation of a screening program;

C directs DHSS to establish a central registry of newborns identified as having or being at risk for developing a hearing loss;

C reconstitutes the Hearing Evaluation Council; and

C Mandates that health, hospital and medical services corporations, individual, small employer and group health insurers, health maintenance organizations and the State Medicaid/NJ KidCare programs provide third party coverage for the newborn testing and monitoring.

FISCAL ANALYSIS

EXECUTIVE BRANCH

DHSS and the Office of Management and Budget (OMB) have estimated the annual cost of the legislation at $211,000, $190,000 and $179,000 in each of the next three fiscal years, respectively. Between $91,000 and $99,000 of this amount would be for personnel costs associated with one professional and one clerical support staff.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services concurs with the department's estimate and adds that current DHSS regulations require that only certain high risk newborns are screened for hearing loss. In 1999, about 45,000 newborns out of about 109,000 births were deemed high risk and screened for hearing loss.

While an additional 64,000 infants would have to be screened, the OLS is not able to estimate the additional costs various health insurers, including the State Health Benefits Program and the Medicaid/NJ KidCare programs, will incur as: (a) the insurance status of the newborns is not known and (b) the cost of an electrophysiologic screening test is not known.

Newborns currently who fail or who require additional follow-up are brought to the attention of DHSS' Special Child, Adult and Early Intervention Services and registered with the Special Child Health Services Registry.

DHSS has adopted regulations that would implement most of the legislation's objectives, effective January 1, 2002, the earliest date hospitals can "develop and organize systems to ensure appropriate follow-up."

Section: *Human Services*

Analyst: *Jay Hershberg*
Principal Fiscal Analyst

Approved: *Alan R. Kooney*
Legislative Budget and Finance Officer

This fiscal note has been prepared pursuant to P.L.1980, c.67.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[First Reprint]
SENATE, No. 1096

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 5, 2001

The Assembly Health Committee reports favorably and with committee amendments Senate Bill No. 1096 (1R).

As amended by the committee, this bill requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2002, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. In addition, the bill provides that the Department of Health and Senior Services (DHSS) shall establish guidelines, to be effective January 1, 2002, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facility. The bill also requires hospitals and birthing centers to report to DHSS how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

C the electrophysiologic screening measure to be used;

C the qualifications of the personnel designated to perform the electrophysiologic screening measure;

C the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;

C the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and

C the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to DHSS.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill provides that the physician or midwife who is caring for the newborn

shall: advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this bill, and take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this bill.

The bill also directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19 (N.J.S.A.26:2-101 et seq.), to provide on-going advice to DHSS on the implementation of the universal newborn hearing screening program. The members shall be appointed by the commission and include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member is to hold office for a term of two years.

The bill mandates that health, hospital and medical service corporations, individual, small employer and group health insurers, and health maintenance organizations, as well as Medicaid and NJ FamilyCare (the FamilyCare Health Coverage Program and the Children's Health Care Coverage Program), provide third party coverage for the newborn testing and monitoring. Also, consistent with the insurance mandates for screening for childhood lead poisoning and childhood immunizations enacted in 1995, the bill provides that no deductible shall be applied to the newborn hearing insurance benefit.

Finally, this bill repeals P.L.1977, c.19, which established the current newborn hearing screening program, since the universal newborn hearing screening program in this bill will replace the current program. (P.L.1977, c.19 does not require that newborns be tested for hearing loss. Rather, each newborn is screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child.)

A fiscal note prepared for this bill indicates that DHSS (with the concurrence of the Office of Legislative Services) has estimated the annual cost of its implementation during the first three fiscal years at $211,000, $190,000 and $179,000, respectively. It should be noted that DHSS has adopted regulations that require the screening of newborns for hearing loss by January 1, 2002.

The committee amended the bill to:

-- require that the FamilyCare Health Coverage Program (as well as the Children's Health Care Coverage Program, as provided in the original bill) provide coverage for the Statewide screening of newborns for hearing loss and periodic monitoring of infants for delayed onset hearing loss;

-- delete the requirement that a physician or midwife, who is caring for a newborn born outside of a hospital or birthing center and not transferred to a hospital or birthing center, shall be responsible for ensuring that the newborn hearing screening requirements established pursuant to this bill are fulfilled before the newborn is 29 days old; and provide instead that the physician or midwife shall advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this bill, and shall take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this bill; and

-- change: the required date for the newborn testing and monitoring from January 1, 2001 to January 1, 2002; and the effective date of the bill from the 180th day after enactment to January 1, 2002.

As reported by the committee, this bill is identical to Assembly Bill No. 2642 Aca (Conaway/Felice), which the committee also reported on this date.

[Second Reprint]

SENATE, No. 1096

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 16, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

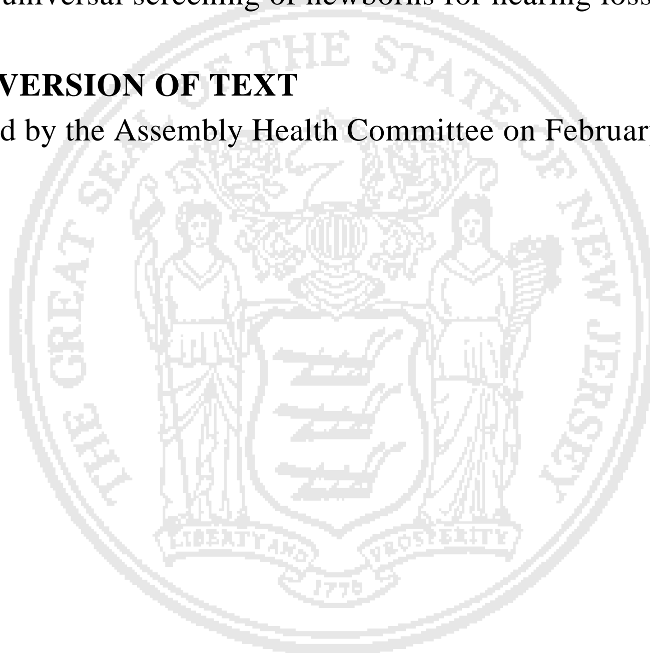
Co-Sponsored by:
Assemblymen Conaway, Felice, Conners, Assemblywoman Friscia, Assemblyman Greenwald, Assemblywomen Weinberg, Heck, Assemblyman Corodemus and Assemblywoman Previte

SYNOPSIS

Mandates universal screening of newborns for hearing loss.

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on February 5, 2001, with amendments.



(Sponsorship Updated As Of: 12/18/2001)

1 **AN ACT** concerning universal newborn hearing screening,
2 supplementing Title 26 of the Revised Statutes, amending
3 P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing
4 P.L.1977, c.19.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) The Legislature finds and declares that:
10 Hearing loss occurs in newborns more frequently than any other
11 health condition for which newborn screening is currently required.
12 Moreover, early detection of hearing loss in a child and early
13 intervention and treatment before six months of age has been
14 demonstrated to be highly effective in facilitating a child's healthy
15 development in a manner consistent with the child's age and cognitive
16 ability. Eighty percent of a child's ability to learn speech, language and
17 related cognitive skills is established by the time the child is 36 months
18 of age, and hearing is vitally important to the healthy development of
19 such language skills. Due to advances in medical technology, children
20 of all ages can receive reliable and valid screening for hearing loss in
21 a cost-effective manner. Appropriate screening and identification of
22 newborns and infants with hearing loss will facilitate early intervention
23 and treatment in the critical time period for language development, and
24 may, therefore, serve the public purposes of promoting the healthy
25 development of children and reducing public expenditures for health
26 care and special education and related services.
27 Therefore, it is necessary for the Legislature to establish a
28 universal newborn hearing screening program that will: a. provide
29 early detection of hearing loss in newborn children at the hospital or
30 birthing center or as soon after birth as possible; b. enable these
31 children and their care givers to obtain needed multi-disciplinary
32 evaluation, treatment, and intervention services at the earliest
33 opportunity; and c. prevent or mitigate the developmental delays and
34 academic failures associated with late identification of hearing loss.
35
36 2. (New section) As used in this act:
37 "Commissioner" means the Commissioner of Health and Senior
38 Services.
39 "Department" means the Department of Health and Senior Services.
40 "Electrophysiologic screening measures" means the electrical result
41 of the application of physiologic agents and includes, but is not limited

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 <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted May 11, 2000.
[2] Assembly AHL committee amendments adopted February 5, 2001.

1 to, the procedures currently known as Auditory Brainstem Response
2 testing (ABR) and Otoacoustic Emissions testing (OAE) and any other
3 procedure adopted by regulation by the commissioner.
4 "Hearing loss" means a hearing loss of 30dB or greater in the
5 frequency region important for speech recognition and comprehension
6 in one or both ears, which is approximately 500 through 4000 Hz.,
7 except that the commissioner may adopt a standard which establishes
8 a less severe hearing loss, as appropriate.
9 "Newborn" means a child up to 28 days old.
10 "Parent" means a biological parent, stepparent, adoptive parent,
11 legal guardian or other legal custodian of a child.
12
13 3. (New section) a. The commissioner shall ensure that, effective
14 January 1, [2]⁅2001⁆ 2002[2] , all newborn children in the State shall be
15 screened for hearing loss by an appropriate eletrophysiologic screening
16 measure.
17 b. Effective January 1, [2]⁅2001⁆ 2002[2] , the department shall issue
18 guidelines for the periodic monitoring of all infants between the age of
19 29 days and 36 months for delayed onset hearing loss.
20 c. Notwithstanding the provisions of subsection a. of this section
21 to the contrary, no newborn child shall be screened for hearing loss if
22 the parent of the newborn objects to such screening on the grounds
23 that the screening conflicts with the parents' bona fide religious tenets
24 or practices.
25
26 4. (New section) Every hospital that provides inpatient maternity
27 services and every birthing center licensed in the State pursuant to
28 P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for
29 newborn screening for hearing loss for all newborns born at the
30 facility. The hospital or birthing center shall file a plan with the
31 department, in a manner and on forms prescribed by the commissioner,
32 detailing how the hospital or birthing center will implement the
33 newborn hearing screening requirements established pursuant to this
34 act. The plan shall include, at a minimum, the following:
35 a. the electrophysiologic screening measure to be performed;
36 b. the qualifications of the personnel designated to perform the
37 electrophysiologic screening measure;
38 c. guidelines for the provision of follow-up services for newborns
39 identified as having or being at risk of developing a hearing loss;
40 d. the educational services to be provided to the parents of
41 newborns identified as having or being at risk for developing a hearing
42 loss; and
43 e. the protocol to be followed to ensure the confidentiality of any
44 patient identifying information furnished to the department for the
45 purposes of the central registry established pursuant to this act.

5. (New section) In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the physician or midwife, licensed in this State pursuant to Title 45 of the Revised Statutes, caring for the newborn shall [2][be responsible for ensuring that the newborn hearing screening requirements established pursuant to this act are fulfilled before the newborn is 29 days old] advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this act, and shall take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this act[2].

6. (New section) a. The commissioner shall establish a central registry of newborns identified as having or being at risk of developing a hearing loss. The information in the central registry shall be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborns listed in the registry.

b. A hospital, birthing center or health care professional who performs testing required by this act shall report the results of such testing when a hearing loss is indicated to the department in a manner and on forms prescribed by the commissioner.

7. (New section) The Commissioner of Human Services shall ensure that the newborn hearing screening and periodic monitoring of infants for delayed onset hearing loss required pursuant to this act is a covered service under the State Medicaid program established pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.) [2][and],[2] the "Children's Health Care Coverage [2][Program,"]Program"[2] established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq)[2], and the "FamilyCare Health Coverage Program" established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.)[2].

8. (New section) The commissioner shall establish a Hearing Evaluation Council to provide on-going advice to the department on implementation of this act. The council shall be composed of not less than seven persons appointed by the commissioner who include: a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf.

Each member shall hold office for a term of two years and until each member's successor is appointed and qualified. Any person appointed to fill a vacancy occurring prior to the expiration of the term for which the person's predecessor was appointed shall be appointed

1 for the remainder of such term.
2 The council shall meet as frequently as the commissioner deems
3 necessary, but not less than once each year. Council members shall
4 receive no compensation but shall be reimbursed for actual expenses
5 incurred in carrying out their duties as members of this council.
6
7 9. The commissioner, pursuant to the "Administrative Procedure
8 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
9 regulations necessary to implement the provisions of this act.
10
11 10. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
12 read as follows:
13 1. No health service corporation contract providing hospital or
14 medical expense benefits for groups with greater than [1][49] 50[1]
15 persons shall be delivered, issued, executed or renewed in this State,
16 or approved for issuance or renewal in this State by the Commissioner
17 of Banking and Insurance on or after the effective date of this act,
18 unless the contract provides benefits to any named subscriber or other
19 person covered thereunder for expenses incurred in the following:
20 a. Screening by blood lead measurement for lead poisoning for
21 children, including confirmatory blood lead testing as specified by the
22 Department of Health and Senior Services pursuant to section 7 of
23 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
24 necessary medical follow-up and treatment for lead poisoned children.
25 b. All childhood immunizations as recommended by the Advisory
26 Committee on Immunization Practices of the United States Public
27 Health Service and the Department of Health and Senior Services
28 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
29 service corporation shall notify its subscribers, in writing, of any
30 change in coverage with respect to childhood immunizations and any
31 related changes in premium. Such notification shall be in a form and
32 manner to be determined by the Commissioner of Banking and
33 Insurance.
34 c. Screening for newborn hearing loss by appropriate
35 electrophysiologic screening measures and periodic monitoring of
36 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
37 (pending before the Legislature as this bill).[1]Payment for this screening
38 service shall be separate and distinct from payment for routine new
39 baby care in the form of a newborn hearing screening fee as negotiated
40 with the provider and facility.[1]
41 The benefits shall be provided to the same extent as for any other
42 medical condition under the contract, except that no deductible shall
43 be applied for benefits provided pursuant to this section. This section
44 shall apply to all health service corporation contracts in which the

1 health service corporation has reserved the right to change the
2 premium.
3 (cf: P.L.1995, c.316, s.1)
4
5 11. 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 [1][49] 50[1]
9 persons shall be delivered, issued, executed or renewed in this State,
10 or approved for issuance or renewal in this State by the Commissioner
11 of Banking and Insurance on or after the effective date of this act,
12 unless the contract provides benefits to any named subscriber or other
13 person covered thereunder for expenses incurred in the following:
14 a. Screening by blood lead measurement for lead poisoning for
15 children, including confirmatory blood lead testing as specified by the
16 Department of Health and Senior Services pursuant to section 7 of
17 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
18 necessary medical follow-up and treatment for lead poisoned children.
19 b. All childhood immunizations as recommended by the Advisory
20 Committee on Immunization Practices of the United State Public
21 Health Service and the Department of Health and Senior Services
22 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
23 service corporation shall notify its subscribers, in writing, of any
24 change in coverage with respect to childhood immunizations and any
25 related changes in premium. Such notification shall be in a form and
26 manner to be determined by the Commissioner of Banking and
27 Insurance.
28 c. Screening for newborn hearing loss by appropriate
29 electrophysiologic screening measures and periodic monitoring of
30 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
31 (pending before the Legislature as this bill).[1]Payment for this screening
32 service shall be separate and distinct from payment for routine new
33 baby care in the form of a newborn hearing screening fee as negotiated
34 with the provider and facility.[1]
35 The benefits shall be provided to the same extent as for any other
36 medical condition under the contract, except that no deductible shall
37 be applied for benefits provided pursuant to this section. This section
38 shall apply to all hospital service corporation contracts in which the
39 hospital service corporation has reserved the right to change the
40 premium.
41 (cf: P.L.1995, c.316, s.2)
42
43 12. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to
44 read as follows:
45 3. No group health insurance policy providing hospital or medical
46 expense benefits for groups with more than [1][49] 50[1] persons shall be

1 delivered, issued, executed or renewed in this State, or approved for
2 issuance or renewal in this State by the Commissioner of Banking and
3 Insurance on or after the effective date of this act, unless the policy
4 provides benefits to any named insured or other person covered
5 thereunder for expenses incurred in the following:
6 a. Screening by blood lead measurement for lead poisoning for
7 children, including confirmatory blood lead testing as specified by the
8 Department of Health and Senior Services pursuant to section 7 of
9 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
10 necessary medical follow-up and treatment for lead poisoned children.
11 b. All childhood immunizations as recommended by the Advisory
12 Committee on Immunization Practices of the United States Public
13 Health Service and the Department of Health and Senior Services
14 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
15 insurer shall notify its policyholders, in writing, of any change in
16 coverage with respect to childhood immunizations and any related
17 changes in premium. Such notification shall be in a form and manner
18 to be determined by the Commissioner of Banking and Insurance.
19 c. Screening for newborn hearing loss by appropriate
20 electrophysiologic screening measures and periodic monitoring of
21 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
22 (pending before the Legislature as this bill).[1]Payment for this screening
23 service shall be separate and distinct from payment for routine new
24 baby care in the form of a newborn hearing screening fee as negotiated
25 with the provider and facility.[1]
26 The benefits shall be provided to the same extent as for any other
27 medical condition under the policy, except that no deductible shall be
28 applied for benefits provided pursuant to this section. This section
29 shall apply to all group health insurance policies in which the health
30 insurer has reserved the right to change the premium.
31 (cf: P.L.1995, c.316, s.3)
32
33 13. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to
34 read as follows:
35 4. A certificate of authority to establish and operate a health
36 maintenance organization in this State shall not be issued or continued
37 by the Commissioner of Health and Senior Services on or after the
38 effective date of this act unless the health maintenance organization
39 offers health care services to any enrollee which include:
40 a. Screening by blood lead measurement for lead poisoning for
41 children, including confirmatory blood lead testing as specified by the
42 Department of Health and Senior Services pursuant to section 7 of
43 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
44 necessary medical follow-up and treatment for lead poisoned children.
45 b. All childhood immunizations as recommended by the Advisory
46 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. , c. (C.) (pending before the Legislature as this bill).[1]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.[1]

The health care services shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

(cf: P.L.1995, c.316, s.4)

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

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

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

b. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no more than 12 months on coverage for preexisting conditions. An

1 individual health benefits plan offered pursuant to section 3 of
2 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
3 condition limitation of any period under the following circumstances:
4 (1) to an individual who has, under creditable coverage, with no
5 intervening lapse in coverage of more than 31 days, been treated or
6 diagnosed by a physician for a condition under that plan or satisfied a
7 12-month preexisting condition limitation; or
8 (2) to a federally defined eligible individual who applies for an
9 individual health benefits plan within 63 days of termination of the
10 prior coverage.
11 c. In addition to the five standard individual health benefits plans
12 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
13 may develop up to five rider packages. Premium rates for the rider
14 packages shall be determined in accordance with section 8 of
15 P.L.1992, c.161 (C.17B:27A-9).
16 d. After the board's establishment of the individual health benefits
17 plans required pursuant to section 3 of P.L.1992, c.161
18 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier
19 shall file the policy or contract forms with the board and certify to the
20 board that the health benefits plans to be used by the carrier are in
21 substantial compliance with the provisions in the corresponding board
22 approved plans. The certification shall be signed by the chief
23 executive officer of the carrier. Upon receipt by the board of the
24 certification, the certified plans may be used until the board, after
25 notice and hearing, disapproves their continued use.
26 e. Effective immediately for an individual health benefits plan
27 issued on or after the effective date of P.L.1995, c.316
28 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
29 date of an individual health benefits plan in effect on the effective date
30 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
31 benefits plans required pursuant to section 3 of P.L.1992, c.161
32 (C.17B:27A-4), including any plan offered by a federally qualified
33 health maintenance organization, shall contain benefits for expenses
34 incurred in the following:
35 (1) Screening by blood lead measurement for lead poisoning for
36 children, including confirmatory blood lead testing as specified by the
37 Department of Health and Senior Services pursuant to section 7 of
38 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
39 necessary medical follow-up and treatment for lead poisoned children.
40 (2) All childhood immunizations as recommended by the Advisory
41 Committee on Immunization Practices of the United States Public
42 Health Service and the Department of Health and Senior Services
43 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
44 shall notify its insureds, in writing, of any change in the health care
45 services provided with respect to childhood immunizations and any
46 related changes in premium. Such notification shall be in a form and

1 manner to be determined by the Commissioner of Banking and
2 Insurance.
3 (3) Screening for newborn hearing loss by appropriate
4 electrophysiologic screening measures and periodic monitoring of
5 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
6 (pending before the Legislature as this bill).[1]Payment for this screening
7 service shall be separate and distinct from payment for routine new
8 baby care in the form of a newborn hearing screening fee as negotiated
9 with the provider and facility.[1]
10 The benefits shall be provided to the same extent as for any other
11 medical condition under the health benefits plan, except that no
12 deductible shall be applied for benefits provided pursuant to this
13 section. This section shall apply to all individual health benefits plans
14 in which the carrier has reserved the right to change the premium.
15 (cf: P.L.1997, c.414, s.1)
16
17 15. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
18 read as follows:
19 3. a. Except as provided in subsection f. of this section, every
20 small employer carrier shall, as a condition of transacting business in
21 this State, offer to every small employer the five health benefit plans
22 as provided in this section. The board shall establish a standard policy
23 form for each of the five plans, which except as otherwise provided in
24 subsection j. of this section, shall be the only plans offered to small
25 groups on or after January 1, 1994. One policy form shall contain the
26 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
27 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
28 carriers, one policy form shall be established which contains benefits
29 and cost sharing levels which are equivalent to the health benefits
30 plans of health maintenance organizations pursuant to the "Health
31 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
32 s.300e et seq.). The remaining policy forms shall contain basic hospital
33 and medical-surgical benefits, including, but not limited to:
34 (1) Basic inpatient and outpatient hospital care;
35 (2) Basic and extended medical-surgical benefits;
36 (3) Diagnostic tests, including X-rays;
37 (4) Maternity benefits, including prenatal and postnatal care; and
38 (5) Preventive medicine, including periodic physical examinations
39 and inoculations.
40 At least three of the forms shall provide for major medical benefits
41 in varying lifetime aggregates, one of which shall provide at least
42 $1,000,000 in lifetime aggregate benefits. The policy forms provided
43 pursuant to this section shall contain benefits representing
44 progressively greater actuarial values.
45 Notwithstanding the provisions of this subsection to the contrary,
46 the board also may establish additional policy forms by which a small

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

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

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

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

1 subsection a. of this section. For the purposes of meeting the
2 requirements of this subparagraph, carriers shall be required to file
3 with the commissioner the health benefits plans issued through an
4 out-of-State trust no later than 180 days after the date of enactment
5 of P.L.1995, c.340. A health benefits plan issued by a carrier through
6 an out-of-State trust that is not filed with the commissioner pursuant
7 to this subparagraph, shall not be permitted to be continued or
8 renewed after the 180-day period.
9 (7) Notwithstanding the provisions of P.L.1992, c.162
10 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
11 employer arrangement or out-of-State trust may offer a health benefits
12 plan authorized to be renewed, continued or reinstated pursuant to this
13 subsection to small employer groups that are otherwise eligible
14 pursuant to paragraph (1) of subsection j. of this section during the
15 period for which such health benefits plan is otherwise authorized to
16 be renewed, continued or reinstated.
17 (8) Notwithstanding the provisions of P.L.1992, c.162
18 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
19 employer arrangement or out-of-State trust may offer coverage under
20 a health benefits plan authorized to be renewed, continued or
21 reinstated pursuant to this subsection to new employees of small
22 employer groups covered by the health benefits plan in accordance
23 with the provisions of paragraph (1) of this subsection.
24 (9) Notwithstanding the provisions of P.L.1992, c.162
25 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
26 the contrary, any individual, who is eligible for small employer
27 coverage under a policy issued, renewed, continued or reinstated
28 pursuant to this subsection, but who would be subject to a preexisting
29 condition exclusion under the small employer health benefits plan, or
30 who is a member of a small employer group who has been denied
31 coverage under the small employer group health benefits plan for
32 health reasons, may elect to purchase or continue coverage under an
33 individual health benefits plan until such time as the group health
34 benefits plan covering the small employer group of which the
35 individual is a member complies with the provisions of P.L.1992, c.162
36 (C.17B:27A-17 et seq.).
37 (10) In a case in which an association made available a health
38 benefits plan on or before March 1, 1994 and subsequently changed
39 the issuing carrier between March 1, 1994 and the effective date of
40 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
41 eligible to continue and renew the plan pursuant to paragraph (1) of
42 this subsection.
43 (11) In a case in which an association, multiple employer
44 arrangement or out-of-State trust made available a health benefits plan
45 on or before March 1, 1994 and subsequently changes the issuing
46 carrier for that plan after the effective date of P.L.1995, c.340, the

new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

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

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

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

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

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

(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. , c. (C.) (pending before the Legislature as this bill).[1]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.[1]

The benefits shall be provided to the same extent as for any other

1 medical condition under the health benefits plan, except that no
2 deductible shall be applied for benefits provided pursuant to this
3 section. This section shall apply to all small employer health benefits
4 plans in which the carrier has reserved the right to change the
5 premium.
6 l. The board shall consider including benefits for speech-language
7 pathology and audiology services, as rendered by speech-language
8 pathologists and audiologists within the scope of their practices, in at
9 least one of the five standard policies and in at least one of the five
10 riders to be developed under this section.
11 (cf: P.L.1997, c.419, s.6)
12
13 16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.
14
15 17. This act shall take effect on [2][the 180th day after enactment]
16 January 1, 2002[2], but the commissioner may take such anticipatory
17 administrative action in advance as shall be necessary for the
18 implementation of the act. The universal newborn hearing screening
19 requirements of sections 10 through 15 of this act shall apply to all
20 policies, contracts and health benefits plans issued or renewed on or
21 after the effective date of this act.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[Second Reprint]

SENATE, No. 1096

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Appropriations Committee reports favorably Senate Bill No. 1096 (2R).

Senate Bill No. 1096 (2R) requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2002, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure.

The bill also requires the Department of Health and Senior Services (DHSS) to establish guidelines, effective January 1, 2002, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facilities. The bill requires hospitals and birthing centers to report to DHSS how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

C the electrophysiologic screening measure to be used;
C the qualifications of the personnel designated to perform the electrophysiologic screening measure;
C the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;
C the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and
C the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to DHSS.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill provides that the physician or midwife who is caring for the newborn shall: advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this bill, and take such actions as may facilitate the provision of such screening to the

newborn in accordance with the provisions of this bill.

The bill directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19 (N.J.S.A.26:2-101 et seq.), to provide on-going advice to DHSS on the implementation of the universal newborn hearing screening program. The members shall be appointed by the commission and include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member is to hold office for a term of two years.

The bill requires that health, hospital and medical service corporations, individual, small employer and group health insurers, and health maintenance organizations, as well as Medicaid and NJ FamilyCare (the FamilyCare Health Coverage Program and the Children's Health Care Coverage Program), provide third party coverage for the newborn testing and monitoring. Also, consistent with the insurance mandates for screening for childhood lead poisoning and childhood immunizations enacted in 1995, the bill provides that no deductible shall be applied to the newborn hearing insurance benefit.

The bill repeals P.L.1977, c.19, which established the current newborn hearing screening program. (The current program does not require that newborns be tested for hearing loss. Currently, each newborn is screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child.)

As reported by the committee, this bill is identical to Assembly Bill No. 2642 (1R), as also reported by the committee.

<u>FISCAL IMPACT</u>:

A fiscal note prepared for this bill indicates that DHSS has estimated the annual cost of its implementation during the first three fiscal years at $211,000, $190,000 and $179,000, respectively. The Office of Legislative Services has noted that DHSS has adopted regulations that implement most of the bill's objectives concerning the screening of newborns for hearing loss by January 1, 2002.

ASSEMBLY, No. 2642

STATE OF NEW JERSEY

209th LEGISLATURE

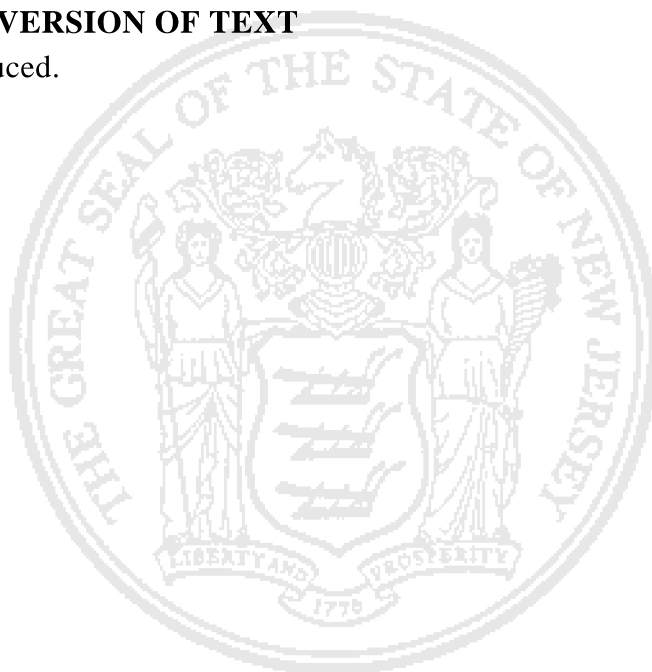
INTRODUCED JUNE 19, 2000

Sponsored by:
Assemblyman HERBERT CONAWAY, JR.
District 7 (Burlington and Camden)
Assemblyman NICHOLAS R. FELICE
District 40 (Bergen and Passaic)

Co-Sponsored by:
Assemblyman Conners, Assemblywoman Friscia, Assemblyman Greenwald and Assemblywoman Weinberg

SYNOPSIS
Mandates universal screening of newborns for hearing loss.

CURRENT VERSION OF TEXT
As introduced.



1 **AN ACT** concerning universal newborn hearing screening,
2 supplementing Title 26 of the Revised Statutes, amending
3 P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing
4 P.L.1977, c.19.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) The Legislature finds and declares that:
10 Hearing loss occurs in newborns more frequently than any other
11 health condition for which newborn screening is currently required.
12 Moreover, early detection of hearing loss in a child and early
13 intervention and treatment before six months of age has been
14 demonstrated to be highly effective in facilitating a child's healthy
15 development in a manner consistent with the child's age and cognitive
16 ability. Eighty percent of a child's ability to learn speech, language and
17 related cognitive skills is established by the time the child is 36 months
18 of age, and hearing is vitally important to the healthy development of
19 such language skills. Due to advances in medical technology, children
20 of all ages can receive reliable and valid screening for hearing loss in
21 a cost-effective manner. Appropriate screening and identification of
22 newborns and infants with hearing loss will facilitate early intervention
23 and treatment in the critical time period for language development, and
24 may, therefore, serve the public purposes of promoting the healthy
25 development of children and reducing public expenditures for health
26 care and special education and related services.
27 Therefore, it is necessary for the Legislature to establish a
28 universal newborn hearing screening program that will: a. provide
29 early detection of hearing loss in newborn children at the hospital or
30 birthing center or as soon after birth as possible; b. enable these
31 children and their care givers to obtain needed multi-disciplinary
32 evaluation, treatment, and intervention services at the earliest
33 opportunity; and c. prevent or mitigate the developmental delays and
34 academic failures associated with late identification of hearing loss.
35
36 2. (New section) As used in this act:
37 "Commissioner" means the Commissioner of Health and Senior
38 Services.
39 "Department" means the Department of Health and Senior Services.
40 "Electrophysiologic screening measures" means the electrical result
41 of the application of physiologic agents and includes, but is not limited
42 to, the procedures currently known as Auditory Brainstem Response
43 testing (ABR) and Otoacoustic Emissions testing (OAE) and any other

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 <u>thus</u> is new matter.

1 procedure adopted by regulation by the commissioner.
2 "Hearing loss" means a hearing loss of 30dB or greater in the
3 frequency region important for speech recognition and comprehension
4 in one or both ears, which is approximately 500 through 4000 Hz.,
5 except that the commissioner may adopt a standard which establishes
6 a less severe hearing loss, as appropriate.
7 "Newborn" means a child up to 28 days old.
8 "Parent" means a biological parent, stepparent, adoptive parent,
9 legal guardian or other legal custodian of a child.
10
11 3. (New section) a. The commissioner shall ensure that, effective
12 January 1, 2001, all newborn children in the State shall be screened
13 for hearing loss by an appropriate eletrophysiologic screening measure.
14 b. Effective January 1, 2001, the department shall issue guidelines
15 for the periodic monitoring of all infants between the age of 29 days
16 and 36 months for delayed onset hearing loss.
17 c. Notwithstanding the provisions of subsection a. of this section
18 to the contrary, no newborn child shall be screened for hearing loss
19 if the parent of the newborn objects to such screening on the grounds
20 that the screening conflicts with the parents' bona fide religious tenets
21 or practices.
22
23 4. (New section) Every hospital that provides inpatient maternity
24 services and every birthing center licensed in the State pursuant to
25 P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for
26 newborn screening for hearing loss for all newborns born at the
27 facility. The hospital or birthing center shall file a plan with the
28 department, in a manner and on forms prescribed by the commissioner,
29 detailing how the hospital or birthing center will implement the
30 newborn hearing screening requirements established pursuant to this
31 act. The plan shall include, at a minimum, the following:
32 a. the electrophysiologic screening measure to be performed;
33 b. the qualifications of the personnel designated to perform the
34 electrophysiologic screening measure;
35 c. guidelines for the provision of follow-up services for newborns
36 identified as having or being at risk of developing a hearing loss;
37 d. the educational services to be provided to the parents of
38 newborns identified as having or being at risk for developing a hearing
39 loss; and
40 e. the protocol to be followed to ensure the confidentiality of any
41 patient identifying information furnished to the department for the
42 purposes of the central registry established pursuant to this act.
43
44 5. (New section) In the case of a newborn born outside of a
45 hospital or birthing center who is not transferred to a hospital or
46 birthing center, the physician or midwife, licensed in this State

1 pursuant to Title 45 of the Revised Statutes, caring for the newborn
2 shall be responsible for ensuring that the newborn hearing screening
3 requirements established pursuant to this act are fulfilled before the
4 newborn is 29 days old.
5
6 6. (New section) a. The commissioner shall establish a central
7 registry of newborns identified as having or being at risk of
8 developing a hearing loss. The information in the central registry shall
9 be used for the purposes of compiling statistical information and
10 providing follow-up counseling, intervention and educational services
11 to the parents of the newborns listed in the registry.
12 b. A hospital, birthing center or health care professional who
13 performs testing required by this act shall report the results of such
14 testing when a hearing loss is indicated to the department in a manner
15 and on forms prescribed by the commissioner.
16
17 7. (New section) The Commissioner of Human Services shall
18 ensure that the newborn hearing screening and periodic monitoring of
19 infants for delayed onset hearing loss required pursuant to this act is
20 a covered service under the State Medicaid program established
21 pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.) and the "Children's
22 Health Care Coverage Program," established pursuant to P.L.1997,
23 c.272 (C.30:4I-1 et seq).
24
25 8. (New section) The commissioner shall establish a Hearing
26 Evaluation Council to provide on-going advice to the department on
27 implementation of this act. The council shall be composed of not less
28 than seven persons appointed by the commissioner who include: a
29 board certified pediatrician, a board certified otolaryngologist, an
30 audiologist with certified clinical competence, a person who is
31 profoundly deaf, a person who is hearing impaired, a hearing person
32 of parents who are deaf, and a citizen of the State who is interested in
33 the concerns and welfare of the deaf.
34 Each member shall hold office for a term of two years and until
35 each member's successor is appointed and qualified. Any person
36 appointed to fill a vacancy occurring prior to the expiration of the term
37 for which the person's predecessor was appointed shall be appointed
38 for the remainder of such term.
39 The council shall meet as frequently as the commissioner deems
40 necessary, but not less than once each year. Council members shall
41 receive no compensation but shall be reimbursed for actual expenses
42 incurred in carrying out their duties as members of this council.
43
44 9. The commissioner, pursuant to the "Administrative Procedure
45 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
46 regulations necessary to implement the provisions of this act.

1 10. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
2 read as follows:
3 1. No health service corporation contract providing hospital or
4 medical expense benefits for groups with greater than [49] 50 persons
5 shall be delivered, issued, executed or renewed in this State, or
6 approved for issuance or renewal in this State by the Commissioner of
7 Banking and Insurance on or after the effective date of this act, unless
8 the contract provides benefits to any named subscriber or other person
9 covered 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 service corporation shall notify its subscribers, in writing, of any
20 change in coverage with respect to childhood immunizations and any
21 related changes in premium. Such notification shall be in a form and
22 manner to be determined by the Commissioner of Banking and
23 Insurance.
24 c. Screening for newborn hearing loss by appropriate
25 electrophysiologic screening measures and periodic monitoring of
26 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
27 (pending before the Legislature as this bill). Payment for this
28 screening service shall be separate and distinct from payment for
29 routine new baby care in the form of a newborn hearing screening fee
30 as negotiated with the provider and facility.
31 The benefits shall be provided to the same extent as for any other
32 medical condition under the contract, except that no deductible shall
33 be applied for benefits provided pursuant to this section. This section
34 shall apply to all health service corporation contracts in which the
35 health service corporation has reserved the right to change the
36 premium.
37 (cf: P.L.1995, c.316, s.1)
38
39 11. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
40 as follows:
41 2. No hospital service corporation contract providing hospital or
42 medical expense benefits for groups with greater than [49] 50 persons
43 shall be delivered, issued, executed or renewed in this State, or
44 approved for issuance or renewal in this State by the Commissioner of
45 Banking and Insurance on or after the effective date of this act, unless
46 the contract provides benefits to any named subscriber or other person

1 covered thereunder for expenses incurred in the following:
2 a. Screening by blood lead measurement for lead poisoning for
3 children, including confirmatory blood lead testing as specified by the
4 Department of Health <u>and Senior Services</u> pursuant to section 7 of
5 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
6 necessary medical follow-up and treatment for lead poisoned children.
7 b. All childhood immunizations as recommended by the Advisory
8 Committee on Immunization Practices of the United State Public
9 Health Service and the Department of Health <u>and Senior Services</u>
10 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
11 service corporation shall notify its subscribers, in writing, of any
12 change in coverage with respect to childhood immunizations and any
13 related changes in premium. Such notification shall be in a form and
14 manner to be determined by the Commissioner of <u>Banking and</u>
15 Insurance.
16 <u>c. Screening for newborn hearing loss by appropriate</u>
17 <u>electrophysiologic screening measures and periodic monitoring of</u>
18 <u>infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)</u>
19 <u>(pending before the Legislature as this bill). Payment for this</u>
20 <u>screening service shall be separate and distinct from payment for</u>
21 <u>routine new baby care in the form of a newborn hearing screening fee</u>
22 <u>as negotiated with the provider and facility.</u>
23 The benefits shall be provided to the same extent as for any other
24 medical condition under the contract, except that no deductible shall
25 be applied for benefits provided pursuant to this section. This section
26 shall apply to all hospital service corporation contracts in which the
27 hospital service corporation has reserved the right to change the
28 premium.
29 (cf: P.L.1995, c.316, s.2)
30
31 12. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to
32 read as follows:
33 3. No group health insurance policy providing hospital or medical
34 expense benefits for groups with more than [49] <u>50</u> persons shall be
35 delivered, issued, executed or renewed in this State, or approved for
36 issuance or renewal in this State by the Commissioner of <u>Banking and</u>
37 Insurance on or after the effective date of this act, unless the policy
38 provides benefits to any named insured or other person covered
39 thereunder for expenses incurred in the following:
40 a. Screening by blood lead measurement for lead poisoning for
41 children, including confirmatory blood lead testing as specified by the
42 Department of Health <u>and Senior Services</u> pursuant to section 7 of
43 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
44 necessary medical follow-up and treatment for lead poisoned children.
45 b. All childhood immunizations as recommended by the Advisory
46 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. , c. (C.) (pending before the Legislature as this bill). 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 shall be provided to the same extent as for any other medical condition under the policy, except that no deductible shall 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.

(cf: P.L.1995, c.316, s.3)

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

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 this act 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. , c. (C.) (pending before the Legislature as this bill). Payment for this screening service shall be separate and distinct from payment for

1 routine new baby care in the form of a newborn hearing screening fee
2 as negotiated with the provider and facility.
3 The health care services shall be provided to the same extent as for
4 any other medical condition under the contract, except that no
5 deductible shall be applied for services provided pursuant to this
6 section. This section shall apply to all contracts under which the
7 health maintenance organization has reserved the right to change the
8 schedule of charges for enrollee coverage.
9 (cf: P.L.1995, c.316, s.4)
10
11 14. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
12 read as follows:
13 6. The board shall establish the policy and contract forms and
14 benefit levels to be made available by all carriers for the health benefits
15 plans required to be issued pursuant to section 3 of P.L.1992, c.161
16 (C.17B:27A-4), and shall adopt such modifications to one or more
17 plans as the board determines are necessary to make available a "high
18 deductible health plan" or plans consistent with section 301 of Title III
19 of the "Health Insurance Portability and Accountability Act of 1996,"
20 Pub.L.104-191, regarding tax-deductible medical savings accounts,
21 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
22 al.). The board shall provide the commissioner with an informational
23 filing of the policy and contract forms and benefit levels it establishes.
24 a. The individual health benefits plans established by the board may
25 include cost containment measures such as, but not limited to:
26 utilization review of health care services, including review of medical
27 necessity of hospital and physician services; case management benefit
28 alternatives; selective contracting with hospitals, physicians, and other
29 health care providers; and reasonable benefit differentials applicable to
30 participating and nonparticipating providers; and other managed care
31 provisions.
32 b. An individual health benefits plan offered pursuant to section 3
33 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
34 more than 12 months on coverage for preexisting conditions. An
35 individual health benefits plan offered pursuant to section 3 of
36 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
37 condition limitation of any period under the following circumstances:
38 (1) to an individual who has, under creditable coverage, with no
39 intervening lapse in coverage of more than 31 days, been treated or
40 diagnosed by a physician for a condition under that plan or satisfied a
41 12-month preexisting condition limitation; or
42 (2) to a federally defined eligible individual who applies for an
43 individual health benefits plan within 63 days of termination of the
44 prior coverage.
45 c. In addition to the five standard individual health benefits plans
46 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board

may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).

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

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

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

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

(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. , c. (C.) (pending before the Legislature as this bill). 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 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

1 section. This section shall apply to all individual health benefits plans
2 in which the carrier has reserved the right to change the premium.
3 (cf: P.L.1997, c.414, s.1)
4
5 15. 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-19b., 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, 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,

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-19b., 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] (C.17B:27A-19.3).

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

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

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

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

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

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

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

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

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

1 its health benefits plan's issuing carrier pursuant to the provisions of
2 this paragraph, shall not, upon changing carriers, modify the benefit
3 structure of that health benefits plan within six months of the date the
4 issuing carrier was changed.
5 k. Effective immediately for a health benefits plan issued on or
6 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and
7 effective on the first 12-month anniversary date of a health benefits
8 plan in effect on the effective date of P.L.1995, c.316
9 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to
10 this section, including any plans offered by a State approved or
11 federally qualified health maintenance organization, shall contain
12 benefits for expenses incurred in the following:
13 (1) Screening by blood lead measurement for lead poisoning for
14 children, including confirmatory blood lead testing as specified by the
15 Department of Health and Senior Services pursuant to section 7 of
16 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
17 necessary medical follow-up and treatment for lead poisoned children.
18 (2) All childhood immunization as recommended by the Advisory
19 Committee on Immunization Practices of the United State Public
20 Health Service and the Department of Health and Senior Services
21 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
22 shall notify its insureds, in writing, of any change in the health care
23 services provided with respect to childhood immunizations and any
24 related changes in premium. Such notification shall be in a form and
25 manner to be determined by the Commissioner of Banking and
26 Insurance.
27 (3) Screening for newborn hearing loss by appropriate
28 electrophysiologic screening measures and periodic monitoring of
29 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
30 (pending before the Legislature as this bill). Payment for this
31 screening service shall be separate and distinct from payment for
32 routine new baby care in the form of a newborn hearing screening fee
33 as negotiated with the provider and facility.
34 The benefits shall be provided to the same extent as for any other
35 medical condition under the health benefits plan, except that no
36 deductible shall be applied for benefits provided pursuant to this
37 section. This section shall apply to all small employer health benefits
38 plans in which the carrier has reserved the right to change the
39 premium.
40 l. 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 (cf: P.L.1997, c.419, s.6)

16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.

17. This act shall take effect on the 180th day after enactment, but the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act. The universal newborn hearing screening requirements of sections 10 through 15 of this act shall apply to all policies, contracts and health benefits plans issued or renewed on or after the effective date of this act.

STATEMENT

This bill requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2001, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. Likewise, the bill provides that the Department of Health and Senior Services establish guidelines, to be effective January 1, 2001, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facility. The bill also requires hospitals and birthing centers to report to the Department of Health and Senior Services how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

- the electrophysiologic screening measure to be used;
- the qualifications of the personnel designated to perform the electrophysiologic screening measure;
- the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;
- the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and
- the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill requires that the physician or midwife who is caring for the newborn ensure that the newborn is screened for hearing loss before the newborn is 29 days old.

1 The bill also directs the commissioner to establish a central registry
2 of newborns identified as having or being at risk for developing a
3 hearing loss. The information in the central registry will be used for
4 the purposes of compiling statistical information and providing follow-
5 up counseling, intervention and educational services to the parents of
6 the newborn.
7 The bill reconstitutes the Hearing Evaluation Council, originally
8 created by P.L.1977, c.19, to provide on-going advice to the
9 department on the implementation of a universal newborn hearing
10 screening program in this State. The members will be appointed by the
11 commission and will include at least seven persons, including a board
12 certified pediatrician, a board certified otolaryngologist, an audiologist
13 with certified clinical competence, a person who is profoundly deaf, a
14 person who is hearing impaired, a hearing person of parents who are
15 deaf, and a citizen of the State who is interested in the concerns and
16 welfare of the deaf. Each member will hold office for a term of two
17 years.
18 The bill mandates that health, hospital and medical service
19 corporations, individual, small employer and group health insurers,
20 health maintenance organizations, and the State Medicaid and NJ
21 KidCare programs provide third party coverage for the newborn
22 testing and monitoring. Also, consistent with the insurance mandates
23 for screening for childhood lead poisoning and childhood
24 immunizations enacted in 1995, the bill provides that no deductible
25 shall be applied to the newborn hearing insurance benefit.
26 Finally, this bill repeals P.L.1977, c.19 (C.26:2-101 et seq.), which
27 established the current newborn hearing screening program, since the
28 universal newborn hearing screening program in this bill will replace
29 the current program.
30 The bill takes effect 180 days after enactment.
31 Currently, State law, N.J.S.A.26:2-101 et seq., does not require
32 that newborns be tested for hearing loss. Rather, each newborn is
33 screened for indicators associated with hearing loss, such as a family
34 history of hereditary childhood hearing loss, meningitis or birth defects
35 affecting the head or neck. If a newborn possesses any one or more
36 of the indicators associated with hearing loss, the parents are advised
37 of the need to have a formal hearing test performed on the child. This
38 bill repeals current law because the universal newborn hearing
39 screening program in this bill will replace the current program.
40 According to the National Conference of State Legislatures, at least
41 23 states have enacted laws mandating universal or nearly universal
42 hearing testing of newborns, and at least nine states mandate health
43 insurance coverage for the testing.

FISCAL NOTE
ASSEMBLY, No. 2642
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: AUGUST 11, 2000

SUMMARY

Synopsis: Mandates universal screening of newborns for hearing loss.

Type of Impact: Possible increase in State expenditures.

Agencies Affected: Department of Health and Senior Services (DHSS).

Executive Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost	$211,000	$190,000	$179,000

! The Office of Legislative Services (OLS) concurs with the department's estimates.

! The Department of Health and Senior Services (DHSS) currently monitors and tracks children at "high risk" for hearing loss and those who failed an initial electrophysiological screening test. This bill would require that all children in the state be screened for hearing loss.

BILL DESCRIPTION

Assembly Bill No. 2642 of 2000 requires DHSS to ensure that, effective January 1, 2001, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. By January 1, 2001, DHSS would also be required to establish guidelines for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss.

Assembly Bill No. 2642 also imposes:

C various administrative requirements on DHSS with respect to implementation of a screening program;

C directs DHSS to establish a central registry of newborns identified as having or being at risk for developing a hearing loss;

C reconstitutes the Hearing Evaluation Council; and

C Mandates that health, hospital and medical services corporations, individual, small employer and group health insurers, health maintenance organizations and the State Medicaid/NJ KidCare programs provide third party coverage for the newborn testing and monitoring.

FISCAL ANALYSIS

EXECUTIVE BRANCH

DHSS and the Office of Management and Budget (OMB) have estimated the annual cost of the legislation at $211,000, $190,000 and $179,000 in each of the next three fiscal years, respectively. Between $91,000 and $99,000 of this amount would be for personnel costs associated with one professional and one clerical support staff.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services (OLS) concurs with the department's estimate and adds that current DHSS regulations require that only certain high risk newborns are screened for hearing loss. In 1999, about 45,000 newborns out of about 109,000 births were deemed high risk and screened for hearing loss.

While an additional 64,000 infants would have to be screened, the OLS is not able to estimate the additional costs various health insurers, including the State Health Benefits Program and the Medicaid/NJ KidCare programs, will incur as: (a) the insurance status of the newborns is not known and (b) the cost of an electrophysiologic screening test is not known.

Newborns currently who fail or who require additional follow-up are brought to the attention of DHSS' Special Child, Adult and Early Intervention Services and registered with the Special Child Health Services Registry.

DHSS has adopted regulations requiring the screening of newborns for hearing loss by January 1, 2002, the earliest date hospitals can "develop and organize systems to ensure appropriate follow-up."

Section: *Human Services*

Analyst: *Jay Hershberg*
Principal Fiscal Analyst

Approved: *Alan R. Kooney*
Legislative Budget and Finance Officer

This fiscal note has been prepared pursuant to P.L.1980, c.67.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2642

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 5, 2001

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 2642.

As amended by the committee, this bill requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2002, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure. In addition, the bill provides that the Department of Health and Senior Services (DHSS) shall establish guidelines, to be effective January 1, 2002, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facility. The bill also requires hospitals and birthing centers to report to DHSS how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

- the electrophysiologic screening measure to be used;
- the qualifications of the personnel designated to perform the electrophysiologic screening measure;
- the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;
- the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and
- the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to DHSS.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill provides that the physician or midwife who is caring for the newborn shall: advise the parent or guardian of the newborn of the availability

of newborn hearing screening pursuant to this bill, and take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this bill.

The bill also directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19 (N.J.S.A.26:2-101 et seq.), to provide on-going advice to DHSS on the implementation of the universal newborn hearing screening program. The members shall be appointed by the commission and include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member is to hold office for a term of two years.

The bill mandates that health, hospital and medical service corporations, individual, small employer and group health insurers, and health maintenance organizations, as well as Medicaid and NJ FamilyCare (the FamilyCare Health Coverage Program and the Children's Health Care Coverage Program), provide third party coverage for the newborn testing and monitoring. Also, consistent with the insurance mandates for screening for childhood lead poisoning and childhood immunizations enacted in 1995, the bill provides that no deductible shall be applied to the newborn hearing insurance benefit.

Finally, this bill repeals P.L.1977, c.19, which established the current newborn hearing screening program, since the universal newborn hearing screening program in this bill will replace the current program. (P.L.1977, c.19 does not require that newborns be tested for hearing loss. Rather, each newborn is screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child.)

A fiscal note prepared for this bill indicates that DHSS (with the concurrence of the Office of Legislative Services) has estimated the annual cost of its implementation during the first three fiscal years at $211,000, $190,000 and $179,000, respectively. It should be noted that DHSS has adopted regulations that require the screening of newborns for hearing loss by January 1, 2002.

The committee amended the bill to:

-- require that the FamilyCare Health Coverage Program (as well

as the Children's Health Care Coverage Program, as provided in the original bill) provide coverage for the Statewide screening of newborns for hearing loss and periodic monitoring of infants for delayed onset hearing loss;

-- delete the requirement that a physician or midwife, who is caring for a newborn born outside of a hospital or birthing center and not transferred to a hospital or birthing center, shall be responsible for ensuring that the newborn hearing screening requirements established pursuant to this bill are fulfilled before the newborn is 29 days old; and provide instead that the physician or midwife shall advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this bill, and shall take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this bill; and

-- change: the required date for the newborn testing and monitoring from January 1, 2001 to January 1, 2002; and the effective date of the bill from the 180th day after enactment to January 1, 2002.

As reported by the committee, this bill is identical to Senate Bill No. 1096 (1R) Aca (Matheussen/Sinagra), which the committee also reported on this date.

[First Reprint]

ASSEMBLY, No. 2642

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED JUNE 19, 2000

Sponsored by:
Assemblyman HERBERT CONAWAY, JR.
District 7 (Burlington and Camden)
Assemblyman NICHOLAS R. FELICE
District 40 (Bergen and Passaic)

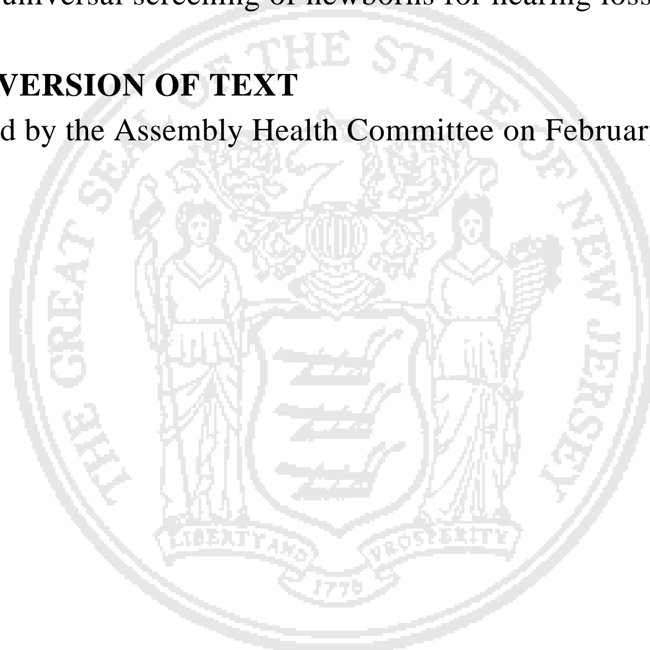
Co-Sponsored by:
Assemblyman Conners, Assemblywoman Friscia, Assemblyman Greenwald, Assemblywomen Weinberg, Heck, Assemblyman Corodemus and Assemblywoman Previte

SYNOPSIS

Mandates universal screening of newborns for hearing loss.

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on February 5, 2001, with amendments.



(Sponsorship Updated As Of: 12/18/2001)

AN ACT concerning universal newborn hearing screening, supplementing Title 26 of the Revised Statutes, amending P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing P.L.1977, c.19.

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

1. (New section) The Legislature finds and declares that:

Hearing loss occurs in newborns more frequently than any other health condition for which newborn screening is currently required. Moreover, early detection of hearing loss in a child and early intervention and treatment before six months of age has been demonstrated to be highly effective in facilitating a child's healthy development in a manner consistent with the child's age and cognitive ability. Eighty percent of a child's ability to learn speech, language and related cognitive skills is established by the time the child is 36 months of age, and hearing is vitally important to the healthy development of such language skills. Due to advances in medical technology, children of all ages can receive reliable and valid screening for hearing loss in a cost-effective manner. Appropriate screening and identification of newborns and infants with hearing loss will facilitate early intervention and treatment in the critical time period for language development, and may, therefore, serve the public purposes of promoting the healthy development of children and reducing public expenditures for health care and special education and related services.

Therefore, it is necessary for the Legislature to establish a universal newborn hearing screening program that will: a. provide early detection of hearing loss in newborn children at the hospital or birthing center or as soon after birth as possible; b. enable these children and their care givers to obtain needed multi-disciplinary evaluation, treatment, and intervention services at the earliest opportunity; and c. prevent or mitigate the developmental delays and academic failures associated with late identification of hearing loss.

2. (New section) As used in this act:

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the Department of Health and Senior Services.

"Electrophysiologic screening measures" means the electrical result of the application of physiologic agents and includes, but is not limited to, the procedures currently known as Auditory Brainstem Response

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted February 5, 2001.

testing (ABR) and Otoacoustic Emissions testing (OAE) and any other procedure adopted by regulation by the commissioner.

"Hearing loss" means a hearing loss of 30dB or greater in the frequency region important for speech recognition and comprehension in one or both ears, which is approximately 500 through 4000 Hz., except that the commissioner may adopt a standard which establishes a less severe hearing loss, as appropriate.

"Newborn" means a child up to 28 days old.

"Parent" means a biological parent, stepparent, adoptive parent, legal guardian or other legal custodian of a child.

3. (New section) a. The commissioner shall ensure that, effective January 1, [1][2001] 2002[1] , all newborn children in the State shall be screened for hearing loss by an appropriate eletrophysiologic screening measure.

b. Effective January 1, [1][2001] 2002[1] , the department shall issue guidelines for the periodic monitoring of all infants between the age of 29 days and 36 months for delayed onset hearing loss.

c. Notwithstanding the provisions of subsection a. of this section to the contrary, no newborn child shall be screened for hearing loss if the parent of the newborn objects to such screening on the grounds that the screening conflicts with the parents' bona fide religious tenets or practices.

4. (New section) Every hospital that provides inpatient maternity services and every birthing center licensed in the State pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for newborn screening for hearing loss for all newborns born at the facility. The hospital or birthing center shall file a plan with the department, in a manner and on forms prescribed by the commissioner, detailing how the hospital or birthing center will implement the newborn hearing screening requirements established pursuant to this act. The plan shall include, at a minimum, the following:

a. the electrophysiologic screening measure to be performed;

b. the qualifications of the personnel designated to perform the electrophysiologic screening measure;

c. guidelines for the provision of follow-up services for newborns identified as having or being at risk of developing a hearing loss;

d. the educational services to be provided to the parents of newborns identified as having or being at risk for developing a hearing loss; and

e. the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department for the purposes of the central registry established pursuant to this act.

5. (New section) In the case of a newborn born outside of a

1 hospital or birthing center who is not transferred to a hospital or
2 birthing center, the physician or midwife, licensed in this State
3 pursuant to Title 45 of the Revised Statutes, caring for the newborn
4 shall [1][be responsible for ensuring that the newborn hearing screening
5 requirements established pursuant to this act are fulfilled before the
6 newborn is 29 days old] advise the parent or guardian of the newborn
7 of the availability of newborn hearing screening pursuant to this act,
8 and shall take such actions as may facilitate the provision of such
9 screening to the newborn in accordance with the provisions of this
10 act[1].
11
12 6. (New section) a. The commissioner shall establish a central
13 registry of newborns identified as having or being at risk of
14 developing a hearing loss. The information in the central registry shall
15 be used for the purposes of compiling statistical information and
16 providing follow-up counseling, intervention and educational services
17 to the parents of the newborns listed in the registry.
18 b. A hospital, birthing center or health care professional who
19 performs testing required by this act shall report the results of such
20 testing when a hearing loss is indicated to the department in a manner
21 and on forms prescribed by the commissioner.
22
23 7. (New section) The Commissioner of Human Services shall
24 ensure that the newborn hearing screening and periodic monitoring of
25 infants for delayed onset hearing loss required pursuant to this act is
26 a covered service under the State Medicaid program established
27 pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.)[1][and],[1] the
28 "Children's Health Care Coverage [1][Program,"] Program"[1] established
29 pursuant to P.L.1997, c.272 (C.30:4I-1 et seq)[1], and the "FamilyCare
30 Health Coverage Program" established pursuant to P.L.2000, c.71
31 (C.30:4J-1 et seq.)[1].
32
33 8. (New section) The commissioner shall establish a Hearing
34 Evaluation Council to provide on-going advice to the department on
35 implementation of this act. The council shall be composed of not less
36 than seven persons appointed by the commissioner who include: a
37 board certified pediatrician, a board certified otolaryngologist, an
38 audiologist with certified clinical competence, a person who is
39 profoundly deaf, a person who is hearing impaired, a hearing person
40 of parents who are deaf, and a citizen of the State who is interested in
41 the concerns and welfare of the deaf.
42 Each member shall hold office for a term of two years and until
43 each member's successor is appointed and qualified. Any person
44 appointed to fill a vacancy occurring prior to the expiration of the term
45 for which the person's predecessor was appointed shall be appointed
46 for the remainder of such term.

1 The council shall meet as frequently as the commissioner deems
2 necessary, but not less than once each year. Council members shall
3 receive no compensation but shall be reimbursed for actual expenses
4 incurred in carrying out their duties as members of this council.
5
6 9. The commissioner, pursuant to the "Administrative Procedure
7 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
8 regulations necessary to implement the provisions of this act.
9
10 10. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
11 read as follows:
12 1. No health service corporation contract providing hospital or
13 medical expense benefits for groups with greater than [49] 50 persons
14 shall be delivered, issued, executed or renewed in this State, or
15 approved for issuance or renewal in this State by the Commissioner of
16 Banking and Insurance on or after the effective date of this act, unless
17 the contract provides benefits to any named subscriber or other person
18 covered thereunder for expenses incurred in the following:
19 a. Screening by blood lead measurement for lead poisoning for
20 children, including confirmatory blood lead testing as specified by the
21 Department of Health and Senior Services pursuant to section 7 of
22 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
23 necessary medical follow-up and treatment for lead poisoned children.
24 b. All childhood immunizations as recommended by the Advisory
25 Committee on Immunization Practices of the United States Public
26 Health Service and the Department of Health and Senior Services
27 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
28 service corporation shall notify its subscribers, in writing, of any
29 change in coverage with respect to childhood immunizations and any
30 related changes in premium. Such notification shall be in a form and
31 manner to be determined by the Commissioner of Banking and
32 Insurance.
33 c. Screening for newborn hearing loss by appropriate
34 electrophysiologic screening measures and periodic monitoring of
35 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
36 (pending before the Legislature as this bill). Payment for this
37 screening service shall be separate and distinct from payment for
38 routine new baby care in the form of a newborn hearing screening fee
39 as negotiated with the provider and facility.
40 The benefits shall be provided to the same extent as for any other
41 medical condition under the contract, except that no deductible shall
42 be applied for benefits provided pursuant to this section. This section
43 shall apply to all health service corporation contracts in which the
44 health service corporation has reserved the right to change the
45 premium.
46 (cf: P.L.1995, c.316, s.1)

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

2. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than [49] 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 this act, 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. , c. (C.) (pending before the Legislature as this bill). 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 shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

(cf: P.L.1995, c.316, s.2)

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

3. No group health insurance policy providing hospital or medical expense benefits for groups with more than [49] 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 this act, unless the policy provides benefits to any named insured or other person covered

1 thereunder for expenses incurred in the following:
2 a. Screening by blood lead measurement for lead poisoning for
3 children, including confirmatory blood lead testing as specified by the
4 Department of Health and Senior Services pursuant to section 7 of
5 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
6 necessary medical follow-up and treatment for lead poisoned children.
7 b. All childhood immunizations as recommended by the Advisory
8 Committee on Immunization Practices of the United States Public
9 Health Service and the Department of Health and Senior Services
10 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
11 insurer shall notify its policyholders, in writing, of any change in
12 coverage with respect to childhood immunizations and any related
13 changes in premium. Such notification shall be in a form and manner
14 to be determined by the Commissioner 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. , c. (C.)
18 (pending before the Legislature as this bill). Payment for this
19 screening service shall be separate and distinct from payment for
20 routine new baby care in the form of a newborn hearing screening fee
21 as negotiated with the provider and facility.
22 The benefits shall be provided to the same extent as for any other
23 medical condition under the policy, except that no deductible shall be
24 applied for benefits provided pursuant to this section. This section
25 shall apply to all group health insurance policies in which the health
26 insurer has reserved the right to change the premium.
27 (cf: P.L.1995, c.316, s.3)
28
29 13. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to
30 read as follows:
31 4. A certificate of authority to establish and operate a health
32 maintenance organization in this State shall not be issued or continued
33 by the Commissioner of Health and Senior Services on or after the
34 effective date of this act unless the health maintenance organization
35 offers health care services to any enrollee which include:
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 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 health
45 maintenance organization shall notify its enrollees, in writing, of any
46 change in the health care services provided with respect to childhood

1 immunizations and any related changes in premium. Such notification
2 shall be in a form and manner to be determined by the Commissioner
3 of Banking and 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. , c. (C.)
7 (pending before the Legislature as this bill). Payment for this
8 screening service shall be separate and distinct from payment for
9 routine new baby care in the form of a newborn hearing screening fee
10 as negotiated with the provider and facility.
11 The health care services shall be provided to the same extent as for
12 any other medical condition under the contract, except that no
13 deductible shall be applied for services provided pursuant to this
14 section. This section shall apply to all contracts under which the
15 health maintenance organization has reserved the right to change the
16 schedule of charges for enrollee coverage.
17 (cf: P.L.1995, c.316, s.4)
18
19 14. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
20 read as follows:
21 6. The board shall establish the policy and contract forms and
22 benefit levels to be made available by all carriers for the health benefits
23 plans required to be issued pursuant to section 3 of P.L.1992, c.161
24 (C.17B:27A-4), and shall adopt such modifications to one or more
25 plans as the board determines are necessary to make available a "high
26 deductible health plan" or plans consistent with section 301 of Title III
27 of the "Health Insurance Portability and Accountability Act of 1996,"
28 Pub.L.104-191, regarding tax-deductible medical savings accounts,
29 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
30 al.). The board shall provide the commissioner with an informational
31 filing of the policy and contract forms and benefit levels it establishes.
32 a. The individual health benefits plans established by the board may
33 include cost containment measures such as, but not limited to:
34 utilization review of health care services, including review of medical
35 necessity of hospital and physician services; case management benefit
36 alternatives; selective contracting with hospitals, physicians, and other
37 health care providers; and reasonable benefit differentials applicable to
38 participating and nonparticipating providers; and other managed care
39 provisions.
40 b. An individual health benefits plan offered pursuant to section 3
41 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
42 more than 12 months on coverage for preexisting conditions. An
43 individual health benefits plan offered pursuant to section 3 of
44 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
45 condition limitation of any period under the following circumstances:
46 (1) to an individual who has, under creditable coverage, with no

intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

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

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

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

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

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

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

<u>(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of</u>

1 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
2 (pending before the Legislature as this bill). Payment for this
3 screening service shall be separate and distinct from payment for
4 routine new baby care in the form of a newborn hearing screening fee
5 as negotiated with the provider and facility.
6 The benefits shall be provided to the same extent as for any other
7 medical condition under the health benefits plan, except that no
8 deductible shall be applied for benefits provided pursuant to this
9 section. This section shall apply to all individual health benefits plans
10 in which the carrier has reserved the right to change the premium.
11 (cf: P.L.1997, c.414, s.1)
12
13 15. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
14 read as follows:
15 3. a. Except as provided in subsection f. of this section, every
16 small employer carrier shall, as a condition of transacting business in
17 this State, offer to every small employer the five health benefit plans
18 as provided in this section. The board shall establish a standard policy
19 form for each of the five plans, which except as otherwise provided in
20 subsection j. of this section, shall be the only plans offered to small
21 groups on or after January 1, 1994. One policy form shall contain the
22 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
23 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
24 carriers, one policy form shall be established which contains benefits
25 and cost sharing levels which are equivalent to the health benefits
26 plans of health maintenance organizations pursuant to the "Health
27 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
28 s.300e et seq.). The remaining policy forms shall contain basic hospital
29 and medical-surgical benefits, including, but not limited to:
30 (1) Basic inpatient and outpatient hospital care;
31 (2) Basic and extended medical-surgical benefits;
32 (3) Diagnostic tests, including X-rays;
33 (4) Maternity benefits, including prenatal and postnatal care; and
34 (5) Preventive medicine, including periodic physical examinations
35 and inoculations.
36 At least three of the forms shall provide for major medical benefits
37 in varying lifetime aggregates, one of which shall provide at least
38 $1,000,000 in lifetime aggregate benefits. The policy forms provided
39 pursuant to this section shall contain benefits representing
40 progressively greater actuarial values.
41 Notwithstanding the provisions of this subsection to the contrary,
42 the board also may establish additional policy forms by which a small
43 employer carrier, other than a health maintenance organization, may
44 provide indemnity benefits for health maintenance organization
45 enrollees by direct contract with the enrollees' small employer through
46 a dual arrangement with the health maintenance organization. The

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

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

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

1 (C.17B:27A-19.3).
2 (b) A carrier which has renewed, continued or reinstated a health
3 benefits plan pursuant to this subsection that has not been newly issued
4 to a new small employer group since January 1, 1994, may, upon
5 approval of the commissioner, continue to establish its rates for that
6 plan based on the loss experience of that plan if the carrier does not
7 issue that health benefits plan to any new small employer groups.
8 (4) (Deleted by amendment, P.L.1995, c.340).
9 (5) A health benefits plan that otherwise conforms to the
10 requirements of this subsection shall be deemed to be in compliance
11 with this subsection, notwithstanding any change in the plan's
12 deductible or copayment.
13 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
14 of this paragraph, a health benefits plan renewed, continued or
15 reinstated pursuant to this subsection shall be filed with the
16 commissioner for informational purposes within 30 days after its
17 renewal date. No later than 60 days after the board adopts regulations
18 concerning the implementation of the rating factors permitted by
19 section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be
20 amended to show any modifications in the plan that are necessary to
21 comply with the provisions of this subsection. The commissioner shall
22 monitor compliance of any such plan with the requirements of this
23 subsection, except that the board shall enforce the loss ratio
24 requirements.
25 (b) A health benefits plan filed with the commissioner pursuant to
26 subparagraph (a) of this paragraph may be amended as to its benefit
27 structure if the amendment does not reduce the actuarial value and
28 benefits coverage of the health benefits plan below that of the lowest
29 standard health benefits plan established by the board pursuant to
30 subsection a. of this section. The amendment shall be filed with the
31 commissioner for approval pursuant to the terms of sections 4, 8, 12
32 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and
33 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and
34 shall comply with the provisions of sections 2 and 9 of P.L.1992,
35 c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995,
36 c.340 (C.17B:27A-19.3).
37 (c) A health benefits plan issued by a carrier through an
38 out-of-State trust shall be permitted to be renewed or continued
39 pursuant to paragraph (1) of this subsection upon approval by the
40 commissioner and only if the benefits offered under the plan are at
41 least equal to the actuarial value and benefits coverage of the lowest
42 standard health benefits plan established by the board pursuant to
43 subsection a. of this section. For the purposes of meeting the
44 requirements of this subparagraph, carriers shall be required to file
45 with the commissioner the health benefits plans issued through an
46 out-of-State trust no later than 180 days after the date of enactment

1 of P.L.1995, c.340. A health benefits plan issued by a carrier through
2 an out-of-State trust that is not filed with the commissioner pursuant
3 to this subparagraph, shall not be permitted to be continued or
4 renewed after the 180-day period.
5 (7) Notwithstanding the provisions of P.L.1992, c.162
6 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
7 employer arrangement or out-of-State trust may offer a health benefits
8 plan authorized to be renewed, continued or reinstated pursuant to this
9 subsection to small employer groups that are otherwise eligible
10 pursuant to paragraph (1) of subsection j. of this section during the
11 period for which such health benefits plan is otherwise authorized to
12 be renewed, continued or reinstated.
13 (8) Notwithstanding the provisions of P.L.1992, c.162
14 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
15 employer arrangement or out-of-State trust may offer coverage under
16 a health benefits plan authorized to be renewed, continued or
17 reinstated pursuant to this subsection to new employees of small
18 employer groups covered by the health benefits plan in accordance
19 with the provisions of paragraph (1) of this subsection.
20 (9) Notwithstanding the provisions of P.L.1992, c.162
21 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
22 the contrary, any individual, who is eligible for small employer
23 coverage under a policy issued, renewed, continued or reinstated
24 pursuant to this subsection, but who would be subject to a preexisting
25 condition exclusion under the small employer health benefits plan, or
26 who is a member of a small employer group who has been denied
27 coverage under the small employer group health benefits plan for
28 health reasons, may elect to purchase or continue coverage under an
29 individual health benefits plan until such time as the group health
30 benefits plan covering the small employer group of which the
31 individual is a member complies with the provisions of P.L.1992, c.162
32 (C.17B:27A-17 et seq.).
33 (10) In a case in which an association made available a health
34 benefits plan on or before March 1, 1994 and subsequently changed
35 the issuing carrier between March 1, 1994 and the effective date of
36 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
37 eligible to continue and renew the plan pursuant to paragraph (1) of
38 this subsection.
39 (11) In a case in which an association, multiple employer
40 arrangement or out-of-State trust made available a health benefits plan
41 on or before March 1, 1994 and subsequently changes the issuing
42 carrier for that plan after the effective date of P.L.1995, c.340, the
43 new issuing carrier shall file the health benefits plan with the
44 commissioner for approval in order to be deemed eligible to continue
45 and renew that plan pursuant to paragraph (1) of this subsection.
46 (12) In a case in which a small employer purchased a health

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

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

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

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

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

(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. , c. (C.) (pending before the Legislature as this bill). 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 shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this section. This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the

1 premium.
2 l. The board shall consider including benefits for speech-language
3 pathology and audiology services, as rendered by speech-language
4 pathologists and audiologists within the scope of their practices, in at
5 least one of the five standard policies and in at least one of the five
6 riders to be developed under this section.
7 (cf: P.L.1997, c.419, s.6)
8
9 16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.
10
11 17. This act shall take effect on [1] [the 180th day after enactment]
12 January 1, 2002[1], but the commissioner may take such anticipatory
13 administrative action in advance as shall be necessary for the
14 implementation of the act. The universal newborn hearing screening
15 requirements of sections 10 through 15 of this act shall apply to all
16 policies, contracts and health benefits plans issued or renewed on or
17 after the effective date of this act.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 2642

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2642 (1R).

Assembly Bill No. 2642 (1R) requires the Commissioner of Health and Senior Services to ensure that, effective January 1, 2002, all children in the State from birth to 28 days old are screened for hearing loss by an appropriate electrophysiologic screening measure.

The bill also requires the Department of Health and Senior Services (DHSS) to establish guidelines, effective January 1, 2002, for the periodic monitoring of all infants between the ages of 29 days and 36 months for delayed onset hearing loss. The bill permits parents of newborns to be exempted from the universal newborn hearing screening program if the screening conflicts with the parents' bona fide religious tenets or practices.

The bill directs hospitals that provide inpatient maternity services and birthing centers to provide newborn screening for hearing loss for all newborns born at their facilities. The bill requires hospitals and birthing centers to report to DHSS how they intend to implement these mandatory newborn hearing screening requirements, including, at least, the following information:

- the electrophysiologic screening measure to be used;
- the qualifications of the personnel designated to perform the electrophysiologic screening measure;
- the guidelines for the provision of follow-up services for newborns identified as having or being at risk for developing a hearing loss;
- the educational services to be provided the parents of the newborn identified as having or being at risk for developing a hearing loss; and
- the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to DHSS.

In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the bill provides that the physician or midwife who is caring for the newborn shall: advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this bill, and take such actions as may facilitate the provision of such screening to the

newborn in accordance with the provisions of this bill.

The bill directs the commissioner to establish a central registry of newborns identified as having or being at risk for developing a hearing loss. The information in the central registry will be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborn.

The bill reconstitutes the Hearing Evaluation Council, originally created by P.L.1977, c.19 (N.J.S.A.26:2-101 et seq.), to provide on-going advice to DHSS on the implementation of the universal newborn hearing screening program. The members shall be appointed by the commission and include at least seven persons, including a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf. Each member is to hold office for a term of two years.

The bill requires that health, hospital and medical service corporations, individual, small employer and group health insurers, and health maintenance organizations, as well as Medicaid and NJ FamilyCare (the FamilyCare Health Coverage Program and the Children's Health Care Coverage Program), provide third party coverage for the newborn testing and monitoring. Also, consistent with the insurance mandates for screening for childhood lead poisoning and childhood immunizations enacted in 1995, the bill provides that no deductible shall be applied to the newborn hearing insurance benefit.

The bill repeals P.L.1977, c.19, which established the current newborn hearing screening program. (The current program does not require that newborns be tested for hearing loss. Currently, each newborn is screened for indicators associated with hearing loss, such as a family history of hereditary childhood hearing loss, meningitis or birth defects affecting the head or neck. If a newborn possesses any one or more of the indicators associated with hearing loss, the parents are advised of the need to have a formal hearing test performed on the child.)

As reported by the committee, this bill is identical to Senate Bill No. 1096 (2R), as also reported by the committee.

FISCAL IMPACT:

A fiscal note prepared for this bill indicates that DHSS has estimated the annual cost of its implementation during the first three fiscal years at $211,000, $190,000 and $179,000, respectively. The Office of Legislative Services has noted that DHSS has adopted regulations that implement most of the bill's objectives concerning the screening of newborns for hearing loss by January 1, 2002.

§§1-9 -
C.26:2-103.1
to 26:2-103.9
§16 - Repealer
§17 - Note to §§1-16

P.L. 2001, CHAPTER 373, ***approved January 8, 2002***
Senate, No. 1096 ***(Second Reprint)***

1 **AN ACT** concerning universal newborn hearing screening,
2 supplementing Title 26 of the Revised Statutes, amending
3 P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing
4 P.L.1977, c.19.
5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*
8
9 1. (New section) The Legislature finds and declares that:
10 Hearing loss occurs in newborns more frequently than any other
11 health condition for which newborn screening is currently required.
12 Moreover, early detection of hearing loss in a child and early
13 intervention and treatment before six months of age has been
14 demonstrated to be highly effective in facilitating a child's healthy
15 development in a manner consistent with the child's age and cognitive
16 ability. Eighty percent of a child's ability to learn speech, language and
17 related cognitive skills is established by the time the child is 36 months
18 of age, and hearing is vitally important to the healthy development of
19 such language skills. Due to advances in medical technology, children
20 of all ages can receive reliable and valid screening for hearing loss in
21 a cost-effective manner. Appropriate screening and identification of
22 newborns and infants with hearing loss will facilitate early intervention
23 and treatment in the critical time period for language development, and
24 may, therefore, serve the public purposes of promoting the healthy
25 development of children and reducing public expenditures for health
26 care and special education and related services.
27 Therefore, it is necessary for the Legislature to establish a
28 universal newborn hearing screening program that will: a. provide
29 early detection of hearing loss in newborn children at the hospital or
30 birthing center or as soon after birth as possible; b. enable these
31 children and their care givers to obtain needed multi-disciplinary
32 evaluation, treatment, and intervention services at the earliest
33 opportunity; and c. prevent or mitigate the developmental delays and
34 academic failures associated with late identification of hearing loss.

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted May 11, 2000.
[2] Assembly AHL committee amendments adopted February 5, 2001.

1 2. (New section) As used in this act:
2 "Commissioner" means the Commissioner of Health and Senior
3 Services.
4 "Department" means the Department of Health and Senior Services.
5 "Electrophysiologic screening measures" means the electrical result
6 of the application of physiologic agents and includes, but is not limited
7 to, the procedures currently known as Auditory Brainstem Response
8 testing (ABR) and Otoacoustic Emissions testing (OAE) and any other
9 procedure adopted by regulation by the commissioner.
10 "Hearing loss" means a hearing loss of 30dB or greater in the
11 frequency region important for speech recognition and comprehension
12 in one or both ears, which is approximately 500 through 4000 Hz.,
13 except that the commissioner may adopt a standard which establishes
14 a less severe hearing loss, as appropriate.
15 "Newborn" means a child up to 28 days old.
16 "Parent" means a biological parent, stepparent, adoptive parent,
17 legal guardian or other legal custodian of a child.
18
19 3. (New section) a. The commissioner shall ensure that, effective
20 January 1, [2]⟦2001⟧ 2002[2] , all newborn children in the State shall be
21 screened for hearing loss by an appropriate eletrophysiologic screening
22 measure.
23 b. Effective January 1, [2]⟦2001⟧ 2002[2] , the department shall issue
24 guidelines for the periodic monitoring of all infants between the age of
25 29 days and 36 months for delayed onset hearing loss.
26 c. Notwithstanding the provisions of subsection a. of this section
27 to the contrary, no newborn child shall be screened for hearing loss if
28 the parent of the newborn objects to such screening on the grounds
29 that the screening conflicts with the parents' bona fide religious tenets
30 or practices.
31
32 4. (New section) Every hospital that provides inpatient maternity
33 services and every birthing center licensed in the State pursuant to
34 P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for
35 newborn screening for hearing loss for all newborns born at the
36 facility. The hospital or birthing center shall file a plan with the
37 department, in a manner and on forms prescribed by the commissioner,
38 detailing how the hospital or birthing center will implement the
39 newborn hearing screening requirements established pursuant to this
40 act. The plan shall include, at a minimum, the following:
41 a. the electrophysiologic screening measure to be performed;
42 b. the qualifications of the personnel designated to perform the
43 electrophysiologic screening measure;
44 c. guidelines for the provision of follow-up services for newborns
45 identified as having or being at risk of developing a hearing loss;
46 d. the educational services to be provided to the parents of

newborns identified as having or being at risk for developing a hearing loss; and

e. the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department for the purposes of the central registry established pursuant to this act.

5. (New section) In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the physician or midwife, licensed in this State pursuant to Title 45 of the Revised Statutes, caring for the newborn shall [2]⟦be responsible for ensuring that the newborn hearing screening requirements established pursuant to this act are fulfilled before the newborn is 29 days old⟧ advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this act, and shall take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this act[2].

6. (New section) a. The commissioner shall establish a central registry of newborns identified as having or being at risk of developing a hearing loss. The information in the central registry shall be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborns listed in the registry.

b. A hospital, birthing center or health care professional who performs testing required by this act shall report the results of such testing when a hearing loss is indicated to the department in a manner and on forms prescribed by the commissioner.

7. (New section) The Commissioner of Human Services shall ensure that the newborn hearing screening and periodic monitoring of infants for delayed onset hearing loss required pursuant to this act is a covered service under the State Medicaid program established pursuant to P.L.1968, c. 413 (C. 30:4D-1 et seq.) [2]⟦and⟧,[2] the "Children's Health Care Coverage [2]⟦Program,"⟧Program"[2] established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq)[2], and the "FamilyCare Health Coverage Program" established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.)[2].

8. (New section) The commissioner shall establish a Hearing Evaluation Council to provide on-going advice to the department on implementation of this act. The council shall be composed of not less than seven persons appointed by the commissioner who include: a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person

1 of parents who are deaf, and a citizen of the State who is interested in
2 the concerns and welfare of the deaf.
3 Each member shall hold office for a term of two years and until
4 each member's successor is appointed and qualified. Any person
5 appointed to fill a vacancy occurring prior to the expiration of the term
6 for which the person's predecessor was appointed shall be appointed
7 for the remainder of such term.
8 The council shall meet as frequently as the commissioner deems
9 necessary, but not less than once each year. Council members shall
10 receive no compensation but shall be reimbursed for actual expenses
11 incurred in carrying out their duties as members of this council.
12
13 9. The commissioner, pursuant to the "Administrative Procedure
14 Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and
15 regulations necessary to implement the provisions of this act.
16
17 10. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to
18 read as follows:
19 1. No health service corporation contract providing hospital or
20 medical expense benefits for groups with greater than [1][49] 50[1]
21 persons shall be delivered, issued, executed or renewed in this State,
22 or approved for issuance or renewal in this State by the Commissioner
23 of Banking and Insurance on or after the effective date of this act,
24 unless the contract provides benefits to any named subscriber or other
25 person covered thereunder for expenses incurred in the following:
26 a. Screening by blood lead measurement for lead poisoning for
27 children, including confirmatory blood lead testing as specified by the
28 Department of Health and Senior Services pursuant to section 7 of
29 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
30 necessary medical follow-up and treatment for lead poisoned children.
31 b. All childhood immunizations as recommended by the Advisory
32 Committee on Immunization Practices of the United States Public
33 Health Service and the Department of Health and Senior Services
34 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health
35 service corporation shall notify its subscribers, in writing, of any
36 change in coverage with respect to childhood immunizations and any
37 related changes in premium. Such notification shall be in a form and
38 manner to be determined by the Commissioner of Banking and
39 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. , c. (C.)
43 (pending before the Legislature as this bill).[1]Payment for this screening
44 service shall be separate and distinct from payment for routine new
45 baby care in the form of a newborn hearing screening fee as negotiated
46 with the provider and facility.[1]

1 The benefits shall be provided to the same extent as for any other
2 medical condition under the contract, except that no deductible shall
3 be applied for benefits provided pursuant to this section. This section
4 shall apply to all health service corporation contracts in which the
5 health service corporation has reserved the right to change the
6 premium.
7 (cf: P.L.1995, c.316, s.1)
8
9 11. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read
10 as follows:
11 2. No hospital service corporation contract providing hospital or
12 medical expense benefits for groups with greater than [1][49] 50[1]
13 persons shall be delivered, issued, executed or renewed in this State,
14 or approved for issuance or renewal in this State by the Commissioner
15 of Banking and Insurance on or after the effective date of this act,
16 unless the contract provides benefits to any named subscriber or other
17 person covered thereunder for expenses incurred in the following:
18 a. 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 b. All childhood immunizations as recommended by the Advisory
24 Committee on Immunization Practices of the United State Public
25 Health Service and the Department of Health and Senior Services
26 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital
27 service corporation shall notify its subscribers, in writing, of any
28 change in coverage 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 c. 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. , c. (C.)
35 (pending before the Legislature as this bill).[1]Payment for this screening
36 service shall be separate and distinct from payment for routine new
37 baby care in the form of a newborn hearing screening fee as negotiated
38 with the provider and facility.[1]
39 The benefits shall be provided to the same extent as for any other
40 medical condition under the contract, except that no deductible shall
41 be applied for benefits provided pursuant to this section. This section
42 shall apply to all hospital service corporation contracts in which the
43 hospital service corporation has reserved the right to change the
44 premium.
45 (cf: P.L.1995, c.316, s.2)

1 12. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) 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 [1][49] 50[1] 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. , c. (C.)
26 (pending before the Legislature as this bill).[1]Payment for this screening
27 service shall be separate and distinct from payment for routine new
28 baby care in the form of a newborn hearing screening fee as negotiated
29 with the provider and facility.[1]
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. This section
33 shall apply to all group health insurance policies in which the health
34 insurer has reserved the right to change the premium.
35 (cf: P.L.1995, c.316, s.3)
36
37 13. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to
38 read as follows:
39 4. A certificate of authority to establish and operate a health
40 maintenance organization in this State shall not be issued or continued
41 by the Commissioner of Health and Senior Services on or after the
42 effective date of this act unless the health maintenance organization
43 offers health care services to any enrollee which include:
44 a. 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 b. 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 health
7 maintenance organization shall notify its enrollees, in writing, of any
8 change in the health care services provided with respect to childhood
9 immunizations and any related changes in premium. Such notification
10 shall be in a form and manner to be determined by the Commissioner
11 of Banking and Insurance.
12 c. 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. , c. (C.)
15 (pending before the Legislature as this bill).[1]Payment for this screening
16 service shall be separate and distinct from payment for routine new
17 baby care in the form of a newborn hearing screening fee as negotiated
18 with the provider and facility.[1]
19 The health care services shall be provided to the same extent as for
20 any other medical condition under the contract, except that no
21 deductible shall be applied for services provided pursuant to this
22 section. This section shall apply to all contracts under which the
23 health maintenance organization has reserved the right to change the
24 schedule of charges for enrollee coverage.
25 (cf: P.L.1995, c.316, s.4)
26
27 14. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
28 read as follows:
29 6. The board shall establish the policy and contract forms and
30 benefit levels to be made available by all carriers for the health benefits
31 plans required to be issued pursuant to section 3 of P.L.1992, c.161
32 (C.17B:27A-4), and shall adopt such modifications to one or more
33 plans as the board determines are necessary to make available a "high
34 deductible health plan" or plans consistent with section 301 of Title III
35 of the "Health Insurance Portability and Accountability Act of 1996,"
36 Pub.L.104-191, regarding tax-deductible medical savings accounts,
37 within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et
38 al.). The board shall provide the commissioner with an informational
39 filing of the policy and contract forms and benefit levels it establishes.
40 a. The individual health benefits plans established by the board
41 may include cost containment measures such as, but not limited to:
42 utilization review of health care services, including review of medical
43 necessity of hospital and physician services; case management benefit
44 alternatives; selective contracting with hospitals, physicians, and other
45 health care providers; and reasonable benefit differentials applicable to
46 participating and nonparticipating providers; and other managed care

1 provisions.
2 b. An individual health benefits plan offered pursuant to section 3
3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
4 more than 12 months on coverage for preexisting conditions. An
5 individual health benefits plan offered pursuant to section 3 of
6 P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting
7 condition limitation of any period under the following circumstances:
8 (1) to an individual who has, under creditable coverage, with no
9 intervening lapse in coverage of more than 31 days, been treated or
10 diagnosed by a physician for a condition under that plan or satisfied a
11 12-month preexisting condition limitation; or
12 (2) to a federally defined eligible individual who applies for an
13 individual health benefits plan within 63 days of termination of the
14 prior coverage.
15 c. In addition to the five standard individual health benefits plans
16 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
17 may develop up to five rider packages. Premium rates for the rider
18 packages shall be determined in accordance with section 8 of
19 P.L.1992, c.161 (C.17B:27A-9).
20 d. After the board's establishment of the individual health benefits
21 plans required pursuant to section 3 of P.L.1992, c.161
22 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier
23 shall file the policy or contract forms with the board and certify to the
24 board that the health benefits plans to be used by the carrier are in
25 substantial compliance with the provisions in the corresponding board
26 approved plans. The certification shall be signed by the chief
27 executive officer of the carrier. Upon receipt by the board of the
28 certification, the certified plans may be used until the board, after
29 notice and hearing, disapproves their continued use.
30 e. Effective immediately for an individual health benefits plan
31 issued on or after the effective date of P.L.1995, c.316
32 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
33 date of an individual health benefits plan in effect on the effective date
34 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
35 benefits plans required pursuant to section 3 of P.L.1992, c.161
36 (C.17B:27A-4), including any plan offered by a federally qualified
37 health maintenance organization, shall contain benefits for expenses
38 incurred in the following:
39 (1) Screening by blood lead measurement for lead poisoning for
40 children, including confirmatory blood lead testing as specified by the
41 Department of Health and Senior Services pursuant to section 7 of
42 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
43 necessary medical follow-up and treatment for lead poisoned children.
44 (2) All childhood immunizations as recommended by the Advisory
45 Committee on Immunization Practices of the United States Public
46 Health Service and the Department of Health and Senior Services

1 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
2 shall notify its insureds, in writing, of any change in the health care
3 services provided with respect to childhood immunizations and any
4 related changes in premium. Such notification shall be in a form and
5 manner to be determined by the Commissioner of Banking and
6 Insurance.
7 (3) Screening for newborn hearing loss by appropriate
8 electrophysiologic screening measures and periodic monitoring of
9 infants for delayed onset hearing loss, pursuant to P.L. , c. (C.)
10 (pending before the Legislature as this bill).[1]Payment for this screening
11 service shall be separate and distinct from payment for routine new
12 baby care in the form of a newborn hearing screening fee as negotiated
13 with the provider and facility.[1]
14 The benefits shall be provided to the same extent as for any other
15 medical condition under the health benefits plan, except that no
16 deductible shall be applied for benefits provided pursuant to this
17 section. This section shall apply to all individual health benefits plans
18 in which the carrier has reserved the right to change the premium.
19 (cf: P.L.1997, c.414, s.1)
20
21 15. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
22 read as follows:
23 3. a. Except as provided in subsection f. of this section, every
24 small employer carrier shall, as a condition of transacting business in
25 this State, offer to every small employer the five health benefit plans
26 as provided in this section. The board shall establish a standard policy
27 form for each of the five plans, which except as otherwise provided in
28 subsection j. of this section, shall be the only plans offered to small
29 groups on or after January 1, 1994. One policy form shall contain the
30 benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187
31 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity
32 carriers, one policy form shall be established which contains benefits
33 and cost sharing levels which are equivalent to the health benefits
34 plans of health maintenance organizations pursuant to the "Health
35 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
36 s.300e et seq.). The remaining policy forms shall contain basic hospital
37 and medical-surgical benefits, including, but not limited to:
38 (1) Basic inpatient and outpatient hospital care;
39 (2) Basic and extended medical-surgical benefits;
40 (3) Diagnostic tests, including X-rays;
41 (4) Maternity benefits, including prenatal and postnatal care; and
42 (5) Preventive medicine, including periodic physical examinations
43 and inoculations.
44 At least three of the forms shall provide for major medical benefits
45 in varying lifetime aggregates, one of which shall provide at least
46 $1,000,000 in lifetime aggregate benefits. The policy forms provided

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

1 this section.
2 Notwithstanding the provisions of this section to the contrary, a
3 health maintenance organization which is approved pursuant to
4 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
5 benefits plans formulated by the board and approved by the
6 commissioner which are in accordance with the provisions of that law
7 in lieu of the five plans required pursuant to this section, except that
8 the plans shall provide the same level of benefits as required for a
9 federally qualified health maintenance organization, including any
10 requirements concerning copayments by enrollees.
11 g. A carrier shall not be required to own or control a health
12 maintenance organization or otherwise affiliate with a health
13 maintenance organization in order to comply with the provisions of
14 this section, but the carrier shall be required to offer the five health
15 benefits plans which are formulated by the board and approved by the
16 commissioner, including one plan which contains benefits and cost
17 sharing levels that are equivalent to those required for health
18 maintenance organizations.
19 h. Notwithstanding the provisions of subsection a. of this section
20 to the contrary, the board may modify the benefits provided for in
21 sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2
22 and 26:2J-4.3).
23 i. (1) In addition to the rider packages provided for in subsection
24 d. of this section, every carrier may offer, in connection with the five
25 health benefits plans required to be offered by this section, any number
26 of riders which may revise the coverage offered by the five plans in
27 any way, provided, however, that any form of such rider or
28 amendment thereof which decreases benefits or decreases the actuarial
29 value of one of the five plans shall be filed for informational purposes
30 with the board and for approval by the commissioner before such rider
31 may be sold. Any rider or amendment thereof which adds benefits or
32 increases the actuarial value of one of the five plans shall be filed with
33 the board for informational purposes before such rider may be sold.
34 The commissioner shall disapprove any rider filed pursuant to this
35 subsection that is unjust, unfair, inequitable, unreasonably
36 discriminatory, misleading, contrary to law or the public policy of this
37 State. The commissioner shall not approve any rider which reduces
38 benefits below those required by sections 55, 57 and 59 of P.L.1991,
39 c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be
40 sold pursuant to this section. The commissioner's determination shall
41 be in writing and shall be appealable.
42 (2) The benefit riders provided for in paragraph (1) of this
43 subsection shall be subject to the provisions of section 2, subsection
44 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162
45 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23,
46 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

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

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

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

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

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

(3) (a) A carrier, association, multiple employer arrangement or

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

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

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

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

(6) (a) Except as otherwise provided in subparagraphs (b) and (c) 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

1 pursuant to paragraph (1) of this subsection upon approval by the
2 commissioner and only if the benefits offered under the plan are at
3 least equal to the actuarial value and benefits coverage of the lowest
4 standard health benefits plan established by the board pursuant to
5 subsection a. of this section. For the purposes of meeting the
6 requirements of this subparagraph, carriers shall be required to file
7 with the commissioner the health benefits plans issued through an
8 out-of-State trust no later than 180 days after the date of enactment
9 of P.L.1995, c.340. A health benefits plan issued by a carrier through
10 an out-of-State trust that is not filed with the commissioner pursuant
11 to this subparagraph, shall not be permitted to be continued or
12 renewed after the 180-day period.
13 (7) Notwithstanding the provisions of P.L.1992, c.162
14 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
15 employer arrangement or out-of-State trust may offer a health benefits
16 plan authorized to be renewed, continued or reinstated pursuant to this
17 subsection to small employer groups that are otherwise eligible
18 pursuant to paragraph (1) of subsection j. of this section during the
19 period for which such health benefits plan is otherwise authorized to
20 be renewed, continued or reinstated.
21 (8) Notwithstanding the provisions of P.L.1992, c.162
22 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple
23 employer arrangement or out-of-State trust may offer coverage under
24 a health benefits plan authorized to be renewed, continued or
25 reinstated pursuant to this subsection to new employees of small
26 employer groups covered by the health benefits plan in accordance
27 with the provisions of paragraph (1) of this subsection.
28 (9) Notwithstanding the provisions of P.L.1992, c.162
29 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to
30 the contrary, any individual, who is eligible for small employer
31 coverage under a policy issued, renewed, continued or reinstated
32 pursuant to this subsection, but who would be subject to a preexisting
33 condition exclusion under the small employer health benefits plan, or
34 who is a member of a small employer group who has been denied
35 coverage under the small employer group health benefits plan for
36 health reasons, may elect to purchase or continue coverage under an
37 individual health benefits plan until such time as the group health
38 benefits plan covering the small employer group of which the
39 individual is a member complies with the provisions of P.L.1992, c.162
40 (C.17B:27A-17 et seq.).
41 (10) In a case in which an association made available a health
42 benefits plan on or before March 1, 1994 and subsequently changed
43 the issuing carrier between March 1, 1994 and the effective date of
44 P.L.1995, c.340, the new issuing carrier shall be deemed to have been
45 eligible to continue and renew the plan pursuant to paragraph (1) of
46 this subsection.

1 (11) In a case in which an association, multiple employer
2 arrangement or out-of-State trust made available a health benefits plan
3 on or before March 1, 1994 and subsequently changes the issuing
4 carrier for that plan after the effective date of P.L.1995, c.340, the
5 new issuing carrier shall file the health benefits plan with the
6 commissioner for approval in order to be deemed eligible to continue
7 and renew that plan pursuant to paragraph (1) of this subsection.
8 (12) In a case in which a small employer purchased a health
9 benefits plan directly from a carrier on or before March 1, 1994 and
10 subsequently changes the issuing carrier for that plan after the
11 effective date of P.L.1995, c.340, the new issuing carrier shall file the
12 health benefits plan with the commissioner for approval in order to be
13 deemed eligible to continue and renew that plan pursuant to paragraph
14 (1) of this subsection.
15 Notwithstanding the provisions of subparagraph (b) of paragraph
16 (6) of this subsection to the contrary, a small employer who changes
17 its health benefits plan's issuing carrier pursuant to the provisions of
18 this paragraph, shall not, upon changing carriers, modify the benefit
19 structure of that health benefits plan within six months of the date the
20 issuing carrier was changed.
21 k. Effective immediately for a health benefits plan issued on or
22 after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and
23 effective on the first 12-month anniversary date of a health benefits
24 plan in effect on the effective date of P.L.1995, c.316
25 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to
26 this section, including any plans offered by a State approved or
27 federally qualified health maintenance organization, shall contain
28 benefits for expenses incurred in the following:
29 (1) Screening by blood lead measurement for lead poisoning for
30 children, including confirmatory blood lead testing as specified by the
31 Department of Health and Senior Services pursuant to section 7 of
32 P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any
33 necessary medical follow-up and treatment for lead poisoned children.
34 (2) All childhood immunization as recommended by the Advisory
35 Committee on Immunization Practices of the United State Public
36 Health Service and the Department of Health and Senior Services
37 pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier
38 shall notify its insureds, in writing, of any change in the health care
39 services provided with respect to childhood immunizations and any
40 related changes in premium. Such notification shall be in a form and
41 manner to be determined by the Commissioner of Banking and
42 Insurance.
43 (3) 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. , c. (C.)
46 (pending before the Legislature as this bill).[1]Payment for this screening

1 service shall be separate and distinct from payment for routine new
2 baby care in the form of a newborn hearing screening fee as negotiated
3 with the provider and facility.[1]
4 The benefits shall be provided to the same extent as for any other
5 medical condition under the health benefits plan, except that no
6 deductible shall be applied for benefits provided pursuant to this
7 section. This section shall apply to all small employer health benefits
8 plans in which the carrier has reserved the right to change the
9 premium.
10 l. The board shall consider including benefits for speech-language
11 pathology and audiology services, as rendered by speech-language
12 pathologists and audiologists within the scope of their practices, in at
13 least one of the five standard policies and in at least one of the five
14 riders to be developed under this section.
15 (cf: P.L.1997, c.419, s.6)
16
17 16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.
18
19 17. This act shall take effect on [2][the 180th day after enactment]
20 January 1, 2002[2], but the commissioner may take such anticipatory
21 administrative action in advance as shall be necessary for the
22 implementation of the act. The universal newborn hearing screening
23 requirements of sections 10 through 15 of this act shall apply to all
24 policies, contracts and health benefits plans issued or renewed on or
25 after the effective date of this act.
26
27
28 ______________
29
30 Mandates universal screening of newborns for hearing loss.

CHAPTER 373

AN ACT concerning universal newborn hearing screening, supplementing Title 26 of the Revised Statutes, amending P.L.1995, c.316, P.L.1992, c.161, P.L.1992, c.162 and repealing P.L.1977, c.19.

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

C.26:2-103.1 Findings, declarations relative to universal newborn hearing screening.

1. The Legislature finds and declares that:

Hearing loss occurs in newborns more frequently than any other health condition for which newborn screening is currently required. Moreover, early detection of hearing loss in a child and early intervention and treatment before six months of age has been demonstrated to be highly effective in facilitating a child's healthy development in a manner consistent with the child's age and cognitive ability. Eighty percent of a child's ability to learn speech, language and related cognitive skills is established by the time the child is 36 months of age, and hearing is vitally important to the healthy development of such language skills. Due to advances in medical technology, children of all ages can receive reliable and valid screening for hearing loss in a cost-effective manner. Appropriate screening and identification of newborns and infants with hearing loss will facilitate early intervention and treatment in the critical time period for language development, and may, therefore, serve the public purposes of promoting the healthy development of children and reducing public expenditures for health care and special education and related services.

Therefore, it is necessary for the Legislature to establish a universal newborn hearing screening program that will: a. provide early detection of hearing loss in newborn children at the hospital or birthing center or as soon after birth as possible; b. enable these children and their care givers to obtain needed multi-disciplinary evaluation, treatment, and intervention services at the earliest opportunity; and c. prevent or mitigate the developmental delays and academic failures associated with late identification of hearing loss.

C.26:2-103.2 Definitions relative to universal newborn hearing screening.

2. As used in this act:

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the Department of Health and Senior Services.

"Electrophysiologic screening measures" means the electrical result of the application of physiologic agents and includes, but is not limited to, the procedures currently known as Auditory Brainstem Response testing (ABR) and Otoacoustic Emissions testing (OAE) and any other procedure adopted by regulation by the commissioner.

"Hearing loss" means a hearing loss of 30dB or greater in the frequency region important for speech recognition and comprehension in one or both ears, which is approximately 500 through 4000 Hz., except that the commissioner may adopt a standard which establishes a less severe hearing loss, as appropriate.

"Newborn" means a child up to 28 days old.

"Parent" means a biological parent, stepparent, adoptive parent, legal guardian or other legal custodian of a child.

C.26:2-103.3 Screening for hearing loss in all newborn children.

3. a. The commissioner shall ensure that, effective January 1, 2002, all newborn children in the State shall be screened for hearing loss by an appropriate electrophysiologic screening measure.

b. Effective January 1, 2002, the department shall issue guidelines for the periodic monitoring of all infants between the age of 29 days and 36 months for delayed onset hearing loss.

c. Notwithstanding the provisions of subsection a. of this section to the contrary, no newborn child shall be screened for hearing loss if the parent of the newborn objects to such screening on the grounds that the screening conflicts with the parents' bona fide religious tenets or practices.

C.26:2-103.4 Hospital, birthing center to provide for newborn screening for hearing loss.

4. Every hospital that provides inpatient maternity services and every birthing center licensed in the State pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to provide for newborn screening for hearing loss for all newborns born at the facility. The hospital or birthing center shall file a plan with the department, in a manner and on forms prescribed by the commissioner, detailing how the hospital or birthing center will implement the newborn hearing screening requirements established pursuant to this act. The plan shall include, at a minimum, the following:

a. the electrophysiologic screening measure to be performed;

b. the qualifications of the personnel designated to perform the electrophysiologic screening measure;

c. guidelines for the provision of follow-up services for newborns identified as having or being at risk of developing a hearing loss;

d. the educational services to be provided to the parents of newborns identified as having or being at risk for developing a hearing loss; and

e. the protocol to be followed to ensure the confidentiality of any patient identifying information furnished to the department for the purposes of the central registry established pursuant to this act.

C.26:2-103.5 Physician, midwife to advise parent of availability of newborn hearing screening.

5. In the case of a newborn born outside of a hospital or birthing center who is not transferred to a hospital or birthing center, the physician or midwife, licensed in this State pursuant to Title 45 of the Revised Statutes, caring for the newborn shall advise the parent or guardian of the newborn of the availability of newborn hearing screening pursuant to this act, and shall take such actions as may facilitate the provision of such screening to the newborn in accordance with the provisions of this act.

C.26:2-103.6 Central registry of newborns at risk of hearing loss.

6. a. The commissioner shall establish a central registry of newborns identified as having or being at risk of developing a hearing loss. The information in the central registry shall be used for the purposes of compiling statistical information and providing follow-up counseling, intervention and educational services to the parents of the newborns listed in the registry.

b. A hospital, birthing center or health care professional who performs testing required by this act shall report the results of such testing when a hearing loss is indicated to the department in a manner and on forms prescribed by the commissioner.

C.26:2-103.7 Screening, monitoring covered service.

7. The Commissioner of Human Services shall ensure that the newborn hearing screening and periodic monitoring of infants for delayed onset hearing loss required pursuant to this act is a covered service under the State Medicaid program established pursuant to P.L.1968, c. 413 (C.30:4D-1 et seq.),the "Children's Health Care Coverage Program"established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.), and the "FamilyCare Health Coverage Program" established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.).

C.26:2-103.8 Hearing Evaluation Council.

8. The commissioner shall establish a Hearing Evaluation Council to provide on-going advice to the department on implementation of this act. The council shall be composed of not less than seven persons appointed by the commissioner who include: a board certified pediatrician, a board certified otolaryngologist, an audiologist with certified clinical competence, a person who is profoundly deaf, a person who is hearing impaired, a hearing person of parents who are deaf, and a citizen of the State who is interested in the concerns and welfare of the deaf.

Each member shall hold office for a term of two years and until each member's successor is appointed and qualified. Any person appointed to fill a vacancy occurring prior to the expiration of the term for which the person's predecessor was appointed shall be appointed for the remainder of such term.

The council shall meet as frequently as the commissioner deems necessary, but not less than once each year. Council members shall receive no compensation but shall be reimbursed for actual expenses incurred in carrying out their duties as members of this council.

C.26:2-103.9 Rules, regulations.
9. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to implement the provisions of this act.

10. 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, immunization.
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 this act, 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 shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

11. 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 this act, 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 shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

12. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) 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 this act, 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 shall be provided to the same extent as for any other medical condition under the policy, except that no deductible shall 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.

13. 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 this act 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 shall be provided to the same extent as for any other medical condition under the contract, except that no deductible shall 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to 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 shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this subsection. This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

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

m. Effective immediately for a health benefits plan issued on or after the effective date of

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

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

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

Repealer.

16. P.L.1977, c.19 (C.26:2-101 et seq.) is repealed.

17. This act shall take effect on January 1, 2002 but the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act. The universal newborn hearing screening requirements of sections 10 through 15 of this act shall apply to all policies, contracts and health benefits plans issued or renewed on or after the effective date of this act.

Approved January 8, 2002.