17:48E-1

LEGISLATIVE HISTORY CHECKLIST
Compiled by the NJ State Law Library

(Audiologists and speech pathologists--reimbursement)

NJSA: 17:48E-1

LAWS OF: 1997 **CHAPTER:** 419

BILL NO: A1418

SPONSOR(S): Garrett

DATE INTRODUCED: February 5, 1996

COMMITTEE: **ASSEMBLY:** Insurance

SENATE: Health

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** February 5, 1996

SENATE: January 8, 1998

DATE OF APPROVAL: January 19, 1998

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: Yes

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

KBP:pp

§2
C. 17:48E-35.17
§3
C. 17:48A-7r
§4
C. 17B:26-2.1p
§5
C. 17B:27-46.1s

P.L. 1997, CHAPTER 419, ***approved January 19, 1998***
Assembly, No. 1418

AN ACT to provide reimbursement under certain health insurance contracts or policies for certain services performed by licensed audiologists and speech-language pathologists, amending P.L.1992, c.162, amending and supplementing P.L.1985, c.236 and supplementing P.L.1940, c.74 (C.17:48A-1 et seq.) and chapters 26 and 27 of Title 17B of the New Jersey Statutes.

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

1. Section 1 of P.L.1985, c.236 (C.17:48E-1) is amended to read as follows:

1. As used in this act:

a. "Commissioner" means the Commissioner of Insurance.

b. "Board" and "board of directors" means the board of directors of the health service corporation.

c. "Elective surgical procedure" means any nonemergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

d. "Eligible physician" means a physician licensed to practice medicine and surgery who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (D.O.) in the surgical or medical specialty for which surgery is proposed.

e. "Health service corporation" means a health service corporation established pursuant to the provisions of this act, which is organized, without capital stock and not for profit, for the purpose of (1) establishing, maintaining and operating a nonprofit health service plan and (2) supplying services in connection with (a) the providing of health care or (b) conducting the business of insurance as provided for in this act.

f. "Health service plan" means a plan under which contracts are issued providing complete or partial prepayment or postpayment of health care services and supplies eligible under the contracts for a given period to persons covered under the contracts where

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.

arrangements are made for payment for health care services and supplies directly to the provider thereof or to a covered person under those contracts.

g. "Hospital service corporation" means a hospital service corporation established pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.).

h. "Medical service corporation" means a medical service corporation established pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.).

i. "Provider of health care services" shall include, but not be limited to: (1) a health service corporation, a hospital service corporation or medical service corporation; (2) a hospital or health care facility under contract with a health service corporation to provide health care services or supplies to persons who become subscribers under contracts with the health service corporation; (3) a hospital or health care facility which is maintained by a state or any of its political subdivisions; (4) a hospital or health care facility licensed by the Department of Health; (5) other hospitals or health care facilities, as designated by the Department of Health to provide health care services; (6) a registered nursing home providing convalescent care; (7) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital; (8) hospitals or other health care facilities located in other states, which are subject to the supervision of those states, which if located in this State would be eligible to be licensed or designated by the Department of Health; (9) nonprofit hospital, medical or health service plans of other states approved by the commissioner; (10) physicians licensed to practice medicine and surgery; (11) licensed chiropractors; (12) licensed dentists; (13) licensed optometrists; (14) licensed pharmacists; (15) licensed chiropodists; (16) registered bio-analytical laboratories; (17) licensed psychologists; (18) registered physical therapists; (19) certified nurse-midwives; (20) registered professional nurses; (21) licensed health maintenance organizations; (22) licensed audiologists; (23) licensed speech-language pathologists; and [22] (24) providers of other similar health care services or supplies as are approved by the commissioner.

j. "Second surgical opinion" means an opinion of an eligible physician based on that physician's examination of a person for the purpose of evaluating the medical advisability of that person undergoing an elective surgical procedure, but prior to the performance of the surgical procedure.

k. "Subscriber" means a person to whom a subscription certificate is issued by a health service corporation, and the term shall also include "policyholder," "member," or "employer" under a group

contract where the context requires.
(cf: P.L.1985, c.236, s.1)

2. (New section) A health service corporation shall offer to provide group contracts covering audiology and speech-language pathology services rendered by a physician or a licensed audiologist or licensed speech-language pathologist where these services are determined to be medically necessary and are performed or rendered within the scope of practice. Notwithstanding this option for group contracts, all group health insurance contracts shall retain current coverage for audiology and speech-language pathology services. Any reimbursement to licensed audiologists and speech-language pathologists for audiology and speech-language pathology services shall be provided to the same extent that the contract authorizes payment for these services to physicians licensed to practice medicine and surgery.

3. (New section) Notwithstanding any other provision of P.L.1940, c.74 (C.17:48A-1 et seq.), benefits shall not be denied to any eligible individual for eligible services, as determined under the terms of the contract or as otherwise required by law, when the services are determined by a physician to be medically necessary and are performed or rendered to that individual by a licensed audiologist or speech-language pathologist within the scope of practice. The practices of audiology and speech-language pathology shall be deemed to be within the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) and duly licensed audiologists and speech-language pathologists shall have such privileges and benefits in the scope of their practice under that act as are afforded thereunder to licensed physicians and surgeons in the scope of their practice.

4. (New section) Notwithstanding any other provision of chapter 26 of Title 17B of the New Jersey Statutes, benefits shall not be denied to any eligible individual for eligible services, as determined by the terms of the policy or as otherwise required by law, when the services are determined by a physician to be medically necessary and are performed or rendered to that individual by a licensed audiologist or speech-language pathologist within the scope of practice. The practices of audiology and speech-language pathology shall be deemed to be within the provisions of chapter 26 of Title 17B of the New Jersey Statutes and duly licensed audiologists and speech-language pathologists shall have such privileges and benefits in the scope of their practice under that act as are afforded thereunder to licensed physicians and surgeons in the scope of their practice.

5. (New section) Notwithstanding any other provision of chapter

27 of Title 17B of the New Jersey Statutes, benefits shall not be denied to any eligible individual for eligible services, as determined by the terms of the policy or as otherwise required by law, when the services are determined by a physician to be medically necessary and are performed or rendered to that individual by a licensed audiologist or speech-language pathologist within the scope of practice. The practices of audiology and speech-language pathology shall be deemed to be within the provisions of chapter 27 of Title 17B of the New Jersey Statutes and duly licensed audiologists and speech-language pathologists shall have such privileges and benefits in the scope of their practice under that act as are afforded thereunder to licensed physicians and surgeons in the scope of their practice.

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

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. §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.

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.).

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

j. (1) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued by or through a carrier, association, multiple employer arrangement or 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, for two successive 12-month periods commencing with the first 12-month anniversary date occurring after February 28, 1994, notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, 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).

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 shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust and an association, multiple employer arrangement or out-of-State trust shall not use actual or expected health status in determining its membership.

(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 carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw a health benefits plan marketed to small employers that was in effect on December 31, 1993 without the approval of the commissioner. The commissioner shall approve a request to withdraw a plan only on the grounds that retention of the plan would present a substantial threat to the financial condition of the carrier.

(4) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan in effect on the effective date of P.L.1994, c.11 (C.17B:27A-19.1 et al.) shall remain in effect until the third 12-month anniversary date occurring after February 28, 1994 of that policy or contract and may, at the option of the policy or contract holder, be renewed or continued until the second 12-month anniversary date of that policy or contract occurring after February 28, 1994.

(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 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.

(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 that were covered by the health benefits plan on December 31, 1993, during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.

(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.).

k. 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.1994, c.11, s.2)

7. This act shall take effect immediately.

STATEMENT

This bill requires health service corporations (Blue Cross and Blue Shield of New Jersey), medical service corporations, and commercial individual and group insurers to reimburse licensed audiologists and speech-language pathologists for services that they perform for insureds if those services are eligible services under the policy or contract.

Under current law, audiologists and speech-language pathologists who practice in a hospital or other institution, by virtue of the setting of their practice, are considered to be qualified providers, and are therefore eligible for direct reimbursement by health insurers. Licensed audiologists and speech-language pathologists in private practice, however, cannot receive direct reimbursement from third party payers because they are not specifically listed as qualified providers under the pertinent statutes. This bill changes current law by including licensed audiologists and speech-language pathologists in the pertinent statutes as qualified providers, and thus makes them eligible for direct reimbursement.

The bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to consider including benefits for speech-language pathology and audiology services in at least one of the five standard policies and in at least one of the five riders to be developed by the board.

Provides that licensed audiologists and speech-language pathologists are eligible for reimbursement under certain health insurance policies.

STATEMENT

This bill requires health service corporations (Blue Cross and Blue Shield of New Jersey), medical service corporations, and commercial individual and group insurers to reimburse licensed audiologists and speech-language pathologists for services that they perform for insureds if those services are eligible services under the policy or contract.

Under current law, audiologists and speech-language pathologists who practice in a hospital or other institution, by virtue of the setting of their practice, are considered to be qualified providers, and are therefore eligible for direct reimbursement by health insurers. Licensed audiologists and speech-language pathologists in private practice, however, cannot receive direct reimbursement from third party payers because they are not specifically listed as qualified providers under the pertinent statutes. This bill changes current law by including licensed audiologists and speech-language pathologists in the pertinent statutes as qualified providers, and thus makes them eligible for direct reimbursement.

The bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to consider including benefits for speech-language pathology and audiology services in at least one of the five standard policies and in at least one of the five riders to be developed by the board.

Provides that licensed audiologists and speech-language pathologists are eligible for reimbursement under certain health insurance policies.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1418

STATE OF NEW JERSEY

DATED: FEBRUARY 15, 1996

The Assembly Insurance Committee reports favorably Assembly Bill No. 1418.

This bill requires health service corporations (Blue Cross and Blue Shield of New Jersey), medical service corporations, and commercial individual and group insurers to reimburse licensed audiologists and speech-language pathologists for services that they perform for insureds if those services are eligible services under the policy or contract.

Under current law, audiologists and speech-language pathologists who practice in a hospital or other institution, by virtue of the setting of their practice, are considered to be qualified providers, and are therefore eligible for direct reimbursement by health insurers. Licensed audiologists and speech-language pathologists in private practice, however, cannot be directly reimbursed by third party payers because they are not specifically listed as qualified providers under the pertinent statutes. This bill changes current law to include licensed audiologists and speech-language pathologists in the pertinent statutes as qualified providers, and thus makes them eligible for direct reimbursement.

The bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to consider including benefits for speech-language-pathology and audiology services in at least one of the five standard policies and in at least one of the five riders to be developed by the board.

SENATE HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1418

STATE OF NEW JERSEY

DATED: DECEMBER 11, 1997

The Senate Health Committee reports favorably Assembly Bill No. 1418.

This bill requires health service corporations (Blue Cross and Blue Shield of New Jersey), medical service corporations and commercial individual and group insurers to reimburse licensed audiologists and speech-language pathologists for services that they perform for insureds if those services are eligible services under the policy or contract.

Under current law, audiologists and speech-language pathologists who practice in a hospital or other institution, by virtue of the setting of their practice, are considered to be qualified providers, and are therefore eligible for direct reimbursement by health insurers. Licensed audiologists and speech-language pathologists in private practice, however, cannot be directly reimbursed by third party payers because they are not specifically listed as qualified providers under the pertinent statutes. This bill changes current law to include licensed audiologists and speech-language pathologists in the pertinent statutes as qualified providers, and thus makes them eligible for direct reimbursement.

The bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to consider including benefits for speech-language-pathology and audiology services in at least one of the five standard policies and in at least one of the five riders to be developed by the board.

This bill is identical to Senate Bill No. 789 SCA (Sinagra), which the committee also reported favorably on this date.