A STUDY OF NEW JERSEY ASSEMBLY BILL 1673

REQUIRES HEALTH INSURERS TO COVER LEAD SCREENING FOR CHILDREN TO AGE 16

Report to the New Jersey Assembly

December 28, 2020

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A1673 (see Appendix I for a copy of the text of the bill). This bill regarding lead screening includes both a practice mandate for providers and facilities, and a coverage mandate for insurers. The bill amends current law to direct physicians and health care facilities to perform lead screening on each child 16 years of age or younger; current law related to directions for providers to screen for lead is set at six years of age. The bill also directs, by referencing N.J.S.A.17:48E-35.10 *et al.*, that insurance coverage for lead screening age requirements be expanded to cover screenings up to age 16, rather than the current requirement of 6 years of age. The practice requirements apply to all New Jersey providers and facilities. The coverage requirements, however, apply only to state-regulated insurance markets, but do not apply to Medicaid, Medicare, self-funded coverage, out-of-state situs plans, the State Health Benefits Program, the School Employees' Health Benefits Program and plans not regulated by the State, but which may cover those receiving care in New Jersey.

The bill statement notes that the "bill will help protect the children of New Jersey from the harms of lead poisoning and elevated blood lead levels. There is no safe level of lead exposure in children, as even low levels of lead in the bloodstream can stunt a child's development. By requiring health insurance companies to cover lead screenings in children who are 16 years of age or younger, the State will be taking a substantial step to detect lead exposure in children before it is too late."

Coverage for preventive services and screening in commercial and self-funded health plans is also governed by federal laws. Specifically, the Patient Protection and Affordable Care Act, Section 2713, amending the Public Health Services Act, and implementing regulations, mandate coverage, requires group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide coverage of certain preventive services. For purposes of screening, the ACA requires coverage of evidence-based items or services that have an "A" or "B" recommendation rating from the United States Preventive Services Task Force (USPSTF). The latest USPSTF finding on lead screening is as follows: "[T]he USPSTF concludes that the current evidence is insufficient, and that the balance of benefits and harms of screening for elevated blood lead levels in asymptomatic children 5 years and younger and in pregnant women cannot be determined."[i] As a result, there is no coverage requirement for lead screening stemming from the ACA.

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The Act does not ask the Commission to recommend whether or not to enact the legislation, and the Commission does not do so here.[ii] The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional

expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections. The MHBAC has sought to include information from a number of reputable sources that it found credible, but recognizes that opinions and analyses may differ.

LEGISLATIVE HISTORY

In the Assembly, A1673 was introduced on January 14, 2020 and was referred to the Assembly Financial Institutions and Insurance Committee. In the immediately prior session, the predecessor version of the bill, A5908, was introduced on November 14, 2019 and referred to the same committee. As of the date of the issuance of this report, the Assembly committee has not considered the bills.

In the Senate, the counterpart to A1673, S837, was introduced January 14, 2020 and was referred to the Senate Health, Human Services and Senior Citizens Committee. In the previous legislative session, the identical bill, S4349, was introduced on January 9, 2020 and was referred to the Senate Commerce Committee. As of the date of the issuance of this report, the Senate committee has not considered the bill.

Because there have been no hearings on the proposed bills concerning lead screening for children up to the age of 16, there are no official stakeholder positions or testimony to cite. There have also not been any fiscal notes published for any of the lead screening bills, so there are no preliminary estimates of associated costs or fiscal impacts available from the Office of Legislative Services.

SOCIAL IMPACT

Prevalence of Lead Toxicity

Lead is a major toxic pollutant, and despite long-term eradication efforts, remains a health threat to one out of three of the world's children.[iii] In the United States, it is estimated that 500,000 children aged 1-5 have blood levels above the 5 micrograms per deciliter (5 µg/dL) considered the upper limit beyond which public health intervention is recommended.[iv] [v] [vi] In 2018, the New Jersey Department of Health's (NJDOH) Childhood Lead Program reported that 4,472 or 2.3% of all NJ children younger than 17 years of age, had an elevated blood lead level above 5 µg/dL.[vii]

Lead: Properties and Toxic Recognition

Lead is a heavy metal naturally occurring in the earth's crust, usually obtained through the refining of mined mineral ores, in particular galena or lead sulfide.[viii] Soft, malleable and resistant to corrosion, lead makes paint more spreadable, speeds drying, and increases its durability by resisting moisture.[ix] [x] It was used in paint by the ancient Greeks, and for plumbing pipes, cooking utensils, drinking vessels, and as a wine preservative, by the ancient Romans. The toxicity of lead began to be recognized during the Renaissance among artisans who worked with lead, and painters who used lead-based paints; Rembrandt and Goya are among those suspected to have suffered from lead poisoning. Between the 17th and 18th centuries, the effects of lead poisoning were described by physicians treating miners, potters working with lead-based glazes, and consumers ingesting lead in wine and cider.[xi]

While the British parliament prevented children from working in white lead factories by 1878, it took until the early 20th century in the United States, for lead to be outlawed in paint for toys and coloring for candy.[xii] Researchers studying lead exposure in a subset of Cleveland residents through uptake in teeth, estimate that two thirds of that uptake could be attributed to inhalation and ingestion related to leaded gasoline whose peak use occurred there between the 1930s and the 1960s.[xiii] [xiv] After the passage of the Clean Air Act in 1970, leaded gasoline was largely phased out in the United States, and banned for use in on-road vehicles as of 1996.[xv] Lead based paint was not outlawed for indoor use in the United State until 1978, and lead soldered cans continued to be used until 1991; in 1995 the Food and Drug Administration issued a final rule prohibiting the use of lead in all food cans, including those that are imported.[xvi] [xvii]

Lead Production and Current Usage in the United States

As primary lead production from mining and smelting ore ended in the United States in 2013 with the closure of the Doe Run Company in Herculaneum, Missouri, the country has increased its importation of refined lead. Secondary lead production continues, principally utilizing lead recycled from lead-acid batteries. Conversely, the manufacture of lead-acid batteries "...accounted for 93% of U.S. lead consumption," in 2019.[xviii] Lead also continues to be used in pigments, ammunition, cable sheathing, weights for lifting, weight belts for diving, lead crystal glass, aprons and vessels for radiation protection, in some solders, to store corrosive chemicals, in roofing, and in stained glass windows.[xix]

Lead Exposure in the United States, including New Jersey

Through a combination of efforts: emission reduction, implementation of occupational safety standards, regulation of lead in food containers, toxic waste clean-up, and remediation of housing containing lead-based paint, estimated mean blood lead levels among U.S. individuals aged 1-74 have decreased 93% (from 12.8 to .82 µ/dL) between 1976-2016.[xx] Still, exposure to lead persists through ingestion and inhalation in the United States, particularly among vulnerable children living in communities where lead pipe plumbing has not been replaced, where dwellings

built before 1978 continue to produce chips and dust from flaking lead paint, and where the soil children play in may be contaminated by lead. These environmental sources of lead disproportionately impact poor and minority communities, in what Whitehead and Buchanan term "a perpetual environmental justice issue."[xxi] Lead exposure can occur in families where adults "import" lead on work clothing or shoes. Sources of lead exposure are detailed in Table 1, below.

TABLE 1
Sources of Lead Exposure

Home Environment Sources	**Other Sources**
Interior or exterior paint; old putty; interior plaster; exterior decorative infrastructure	Folk remedies: examples include Ayurvedic medicines; Greta and Azarcon, Hispanic traditional medicines; Ghasard, an Indian folk medicine; 'pay-loo-ah'; 'litarigio'; 'bali bali'; 'Babaw-saw', a Chinese herbal remedy; reuda; liga; coral; alkoh)
Household lead-laden dust	Foodstuffs: Some garden plants grown in contaminated soil (e.g., leafy or root vegetables)
Lead-contaminated Soil	Herbs and dietary supplements: imported herbal products; dietary supplements (e.g, calcium); imported spices (e.g., turmeric); candy from Mexico (the ingredient 'tamarind' may contain lead)
Drinking water; household lead plumbing; standpipes; water mains; faucets; lead-soldered pipes	Cosmetics and religious powders: 'Swad' brand Sindoor, a cosmetic product used in Hinduism); 'Tiro' eye cosmetic from Nigeria; 'Kohl' or 'Surma' eye cosmetics from Africa, Middle East or Asia; lead acetate hair dyes
Parental occupations: 'Take-Home' Lead (examples include construction, renovation, and demolition work, lead-paint abatement, pipe fitting and plumbing, battery manufacturing, mining, ship building or other marine work, e-scrap recycling)	Hobbies: examples include hobbies involving soldering such as stained glass; making fishing lures/sinkers; jewelry making; pottery glazes; some artists' paints (flake white); fabricating bullets; lead solder use; marksmanship at firing ranges; pool cue chalk
Old ceramic, pewter, or antique cookware; old pots, pans, urns/ kettles; decorative pottery from Mexico; ceramics from China, or other imported cookware	Marine lead sources: marine paints, lead weights
Hazardous neighborhoods: homes located near lead-smelters, mining; nearby homes undergoing demolition; toxic waste sites; homes under bridges; homes near incinerators; battery recycling facilities	Moonshine alcoholic beverages
Secondary home environments: family daycare, grandparents' homes, homes of other family members where children spend substantial time	Fishing sinkers; curtain weights; automobile wheel balancing weights; ammunition (including pellets); lead tools; vinyl blinds sold before 1997
Home renovations	Novelty jewelry; charms; medallions
Burning painted wood indoors	Some imported toy; crayons, pewter figurines
Antique cribs or furniture	Leaded Aviation gasoline ('Avgas' for small piston-engine planes); leaded gas for racing cars, marine vessels

From: Hauptman, M., Bruccoleri, R. and Woolf, A. Update on Childhood Lead Poisoning. Clin Pediatr Emerg Med. 2017 Sep;18(3): p.3; Data from: Etzel RA, Balk SJ (Editors). Pediatric environmental health. 3rd Ed. Elk Grove Village, IL: American Academy of Pediatrics; 2011. American Academy of Pediatrics Council of Environmental Health.

Those most at risk of lead toxicity include babies and toddlers who explore the world through their mouths, developmentally disabled or autistic children who persist in pica behavior into adolescence, children living at or below the poverty line, non-Hispanic African-American children, immigrant children, children in foster care, pregnant women and those working in industries or jobs involving lead.[xxii] [xxiii] [xxiv] High lead levels in public water, as a result of lead leaching from pipes after anti-corrosion failures over the past two decades, have led to elevated lead levels in children in those cities, including but not limited to Washington, D.C., Flint, Michigan and Newark, New Jersey.[xxv] [xxvi]

New Jersey contains more Superfund sites than any other state (115), not all of which have been contained, and an unknown number of which include lead among the contaminants.[xxviii] One example: in 2007, it was discovered that the Old Bridge waterfront park on Raritan Bay was contaminated by lead sludge used in its construction, material that had been dumped there from a nearby lead plant in the 1960s and 1970s; after being named a Superfund site by the Environmental Protection Agency in 2009, remediation efforts paid by National Lead, the source of the original sludge, finally began in 2013; they are not yet complete.[xxix] [xxx] The NJDOH estimates that there are more than 2.4 million housing units in the state built before 1980, when lead-based paint was disallowed for indoor use; the highest percentage of these housing units are in Union, Passaic and Essex counties.[xxxi]

On September 17, 2017, the NJDOH lowered the elevated blood level standard (EBLL) at which local health departments are required to intervene, from 10ug/dL to 5ug/dL, matching the upper limit recommended by the Centers for Disease Control and Prevention (CDC) in 2012.[xxxiii] [xxxiv] In its latest publicly available summary, the NJDOH identified the communities as those with the highest percentage of children whose blood lead levels were at or exceeded 5µg/dL as: Trenton and Irvington (6.4%); East Orange (5.0%), Atlantic City (4.8%) and the City of Newark (4.4%).[xxxv]

MEDICAL EVIDENCE

Health Effects of Lead in Children

Lead plays no biological role in the human body, and there is no "safe" blood level of lead.[xxxvi]

The CDC lowered the recommended upper limits of blood lead from 10µg/dL to 5µg/dL in 2012 after reviewing persuasive evidence that lead levels below 10µg/dL are associated with toxic effects in children; these toxic effects include increased inattention, hyperactivity-impulsivity, and cognitive deficits, negatively impacting school performance.[xl] [xli] Canfield and colleagues estimate that for the children they studied, IQ decreased by 7.4 points as the lifetime average of blood lead level concentrations increased from 1 to 10µg/dL, and conclude that neurotoxicity due to lead is both "permanent and irreversible.[xlii]

Elevated blood lead levels can affect overall growth in children from conception onward: blood lead levels greater than 5µg/dL among pregnant women are associated with reduced fetal growth and lower birth weight, while blood lead levels below 10 µg/dL are associated with decreased postnatal growth. When blood lead levels in children exceed 10µg/dL, they may be observed to have reduced head circumference and height, and delayed puberty.[xliii] Children who have experienced lead poisoning are at increased risk for hypertension, decreased renal function, and reproductive problems, including infertility, as adults.[xliv] [xlv]

Table 2 Health Effects on Children by Blood Lead Level: Sufficient or Causal Evidence

Below 5µg/dL	Nervous System Effects: Cognitive function: decreased IQ, academic achievement Externalizing behaviors: Increased incidence of attention-related and problem behaviors
5-10 µg/dL	Effects listed above plus Nervous System Effects: decreased auditory function Reproductive and Developmental Effects: reduced postnatal growth, delayed puberty for girls and boys
10-44µg/dL	Effects listed above plus: Nervous System Effects: slower nerve conduction Hematologic Effects: decreased hemoglobin, anemia
45-69µg/dL	Effects listed above plus: Gastrointestinal Effects: abdominal pain, constipation, colic, anorexia and vomiting
Above 70µg/dL	Effects listed above plus: Nervous system effects: severe neural effects including convulsions, coma, loss of voluntary muscle control and death

Source: President's Task Force on Environmental Health Risks and Safety Risks to Children: Key Federal Programs to Reduce Childhood Lead Exposures and Eliminate Associated Health Impacts Report. November, 2016. (Google).
Data from: National Toxicology Program (NTP). Monograph on Health Effects of Low-Level Lead. Executive Summary, p. XX. Research Triangle Park, NC. June 13, 2012. (https://ntp.niehs.nih.gov/whatwestudy/assessments/noncancer/completed/lead/index.html; U.S. EPA. Integrated Science Assessment (ISA) for Lead (Final Report, Jul 2013). U.S. Environmental Protection Agency, Washington, DC, EPA/600/R-10/075F, 2013. (https://cfpub.epa.gov/ncea/isa/recordisplay.cfm?deid=255721)

Lead Absorption, Distribution and Impact on the Body

Lead is absorbed through ingestion and inhalation, and excreted through renal clearance, in urine or biliary clearance, in feces. The smaller the particle, the greater the quantity of lead absorbed, so lead dust or lead that is inhaled in fumes is more immediately toxic than lead chips. Children can swallow lead in the form of lead shot, small leaded toys, and small leaded weights, leading to sudden and urgently high lead levels. Once inhaled or ingested, lead is distributed in blood, soft tissue, bones, and teeth. The elimination half-life of lead in children's blood may be as long as 10 months, in soft tissue, 40 days, and in cortical bone, 10-30 years. Lead present in bone can be released to blood during pregnancy, lactation, menopause, physiologic stress, chronic disease, hyperthyroidism, kidney disease or advanced age, thus posing a health threat long after its initial absorption. Lead can, additionally, directly interfere with bone matrix formation, mineralization

and resorption through disruption of hormonal regulation.[xlvi] Lead interferes with iron absorption and heme synthesis, and iron insufficiency and iron deficiency anemia are common co-morbidities in children with elevated blood lead levels.[xlvii] An interruption in heme synthesis can also contribute to impaired cell growth, maturation and tooth and bone development in malnourished children who have suffered chronic lead toxicity. Lead exposure can damage kidneys, and when severe, produce lead colic (acute abdominal pain), encephalopathy, and death.

At the molecular level, lead disrupts calcium utilization. Although this results in toxic effects on all body systems, the brain is an especially sensitive end-point organ, with the brain of a young, developing child at a particular risk for damage. Lead can cross the blood-brain barrier and interfere with the activity of neurotransmitters; its effects on glutamatergic transmission can limit learning, memory and affect mood, and on dopaminergic transmission, negatively impact motor control, attention, memory, and executive functioning.[xlix]

Applying MRI data analysis, Cecil and colleagues determined that reduced brain volume is associated with childhood lead concentrations; most notably affected is the prefrontal cortex, responsible for executive functions, mood regulation and decision-making; a reduction in size of the cerebellum was also found and is related to diminished fine motor control. These anatomical changes were more pronounced in men than in women, which the authors conclude may explain the higher incidence of antisocial behavior in men.[l] An increasing body of medical evidence links childhood lead exposure to conduct disorders, delinquency and criminality in children, adolescents and young adults.[li] [lii] [liii] A study of lead exposure in the city of St. Louis, Missouri demonstrated that aggregate blood lead levels in children were significant predictors of all violent crimes except rape at the census tract level, including crimes involving a firearm, assault, robbery, and homicide.[liv]

Lead Screening

Lead poisoning can be insidious, and symptoms related to elevated lead levels may not appear in some children until those levels are extremely high. Since there is no known safe threshold for lead, all children should be screened. The lead screening schedule required by regulation in the state of New Jersey, is consistent with recommendations published by the ATSDR (CDC) in June 2017.[lv] A summary of the rule is detailed below:

N.J.A.C.8:51A-2.2 Lead Screening Schedule:

(a) Every physician, registered professional nurse, as appropriate, or health care facility, unless exempt pursuant to N.J.A.C. 8:51A-2.3, shall perform lead screening on each patient who is at least six months and less than 72 months of age according to the following schedule:

1. Lead screening shall be performed on each child: **i.** Between nine and 18 months of age, preferably at, or as close as possible to, 12 months of age; and **ii.** Between 18 and 26 months of age, preferably at, or as

close as possible to, 24 months of age. The second test shall be performed no sooner than six months following the first test.

2. For children found to be at high risk for lead exposure, as determined by the risk assessment performed pursuant to N.J.A.C. 8:51A-2.1:**i.** Each child between six and 24 months of age shall be screened, unless he or she has been screened within the previous six months; and **ii.** Each child at least six months and less than 72 months of age shall be screened when the risk assessment indicates exposure to a new high dose source of lead since the last time that he or she was screened. Examples of a new high dose source include, but are not limited to, a recent renovation of the child's residence (if built before 1960 or if lead-based paint is known to be present), deterioration of the paint in the child's residence, moving into a house built prior to 1960 that has peeling, chipping, or deteriorated paint, or an adult living in the household undertaking a new job or hobby that involves exposure to lead.

3. Each child older than 26 months of age but less than 72 months of age shall be screened if the child has never previously been screened for elevated blood lead levels.[lvi]

The CDC also recommends lead screening for:

- All immigrant children regardless of age upon arrival in the United States
- Pregnant and lactating women
- Neonates and infants of women with blood lead levels greater than 5µg/dL[lvii]

A reasonable case could be made that the age for mandated health insurance coverage of lead screening in New Jersey children be extended from age 6 to age 16, in all those:

- Who have not been previously screened
- Who are pregnant or lactating
- Who are new immigrants
- Who are special needs children continuing to engage in pica
- Who may have experienced workplace lead exposure
- Who may engage in hobbies involving lead exposure (e.g., marksmanship at firing ranges; ceramics and painting, as flake white paint used in painting still contains lead).

OTHER STATES

No other state has proposed legislation to mandate insurance coverage for lead screening in children up to the age of 16. In the United States, there is a patchwork of Federal and state policies and recommendations to test younger children. This patchwork includes Medicaid lead screening standards, state policies for universal lead testing of younger children, state programs targeting screening on younger children at greater risk of elevated blood lead levels, states with lead screening recommendations, and states lacking lead screening policies altogether.[lviii]

The guidelines for children receiving Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit require that children's blood lead levels be tested at 12 months and 24 months,

and at ages up to 6 years, if children have not been previously tested.[lix] In 2012 the Centers for Medicare and Medicaid Services (CMS) revised these guidelines to permit states to target additional testing for Medicaid-enrolled children at older ages if the states could provide data to demonstrate that additional and more focused screenings would better identify children at risk of elevated blood lead levels.[lx]

Ten states and the District of Columbia have universal lead testing policies with generally similar guidelines, see Table 3. Nearly all of these states require universal lead screening for children at approximately 12 and 24 months of age. Several states add a screening requirement at 36 months of age. Delaware only requires screening for all children at 12 months of age, and Iowa requires that all children be screened before entering kindergarten or as soon thereafter as possible.[lxi]

Table 3. States with Universal Childhood Lead Testing Policies

State	Policy
Massachusetts	Universal testing – 9-12 months, 24 months, and 36 months
Vermont	Universal testing – 12 months and 24 months
Rhode Island	Universal testing – 9-15 months and 21-27 months
Connecticut	Universal testing – annually 9 through 35 months
District of Columbia	Universal testing – 6-14 months and 22-26 months
Iowa	Universal testing – all children seeking to enter kindergarten, by 6 years or right after
New York	Universal testing – around 12 months and 24 months
Maryland	Universal testing – at 12 months, 24 months, and 36 months

New Jersey	Universal testing – around 12 months and 24 months
Louisiana	Universal testing – at 12 months and 24 months
Delaware	Universal Testing – at or around 12 months

Source: Safer Chemicals, Healthy Families, Saferchemicals.org, https://saferchemicals.org/get-the-facts/children-at-risk/table-1a/

An additional eight states have lead testing requirements for children that go beyond or in addition to Medicaid guidelines, but fall short of mandatory universal screening. These states include California, Illinois, Maine, Michigan, Missouri, Ohio, Virginia, and West Virginia. These states focus screening attention on children who live in areas with older housing, near lead smelters, or in areas with elevated lead levels in drinking water.[lxii]

There are another 27 states that offer recommendations for lead screening of young children. These recommendations are not requirements, and they are offered for children who are not enrolled in the state's Medicaid program.[lxiii] The recommendations tend to mirror the guidelines set out in the policies of the states with targeted lead screening programs. Finally, there are five states with no formal, published childhood lead testing policies. These are Wyoming, Arkansas, Montana, North Dakota, and South Dakota.[lxiv]

DISCUSSION

Table 4 presents the lead screening recommendations of a number of medical practice, public health, and governmental organizations. The blood level testing recommendations are varied, and none of the organizations recommend lead screening of children beyond the age of 6.

Table 4. Lead Screening Recommendations of Leading Organizations

Organization	Lead Screening Recommendation
American Academy of Family Physicians	Against routine screening of asymptomatic children aged 1 to 5 years at average risk; found insufficient evidence on screening of children at increased risk
American Academy of Pediatrics	Recommends screening of children based on federal, state, and local requirements; additional screening for children at higher risk

	or from foreign countries
Medicaid Early and Periodic Screening, Diagnostic, and Treatment Program	Requires all children receive blood level tests at 12 and 24 months; screening for all children between 36 and 72 months who have not been previously tested for lead poisoning
Bright Futures	Recommends screening according to state law, and universal screening at ages 12 and 24 months in states with no screening program in place
Centers for Disease Control and Prevention	Recommends screening for children at increased risk for lead exposure
American College of Preventive Medicine	Recommends screening for children at increased risk for lead exposure

Source: US Preventive Services Task Force
https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/elevated-blood-lead-levels-in-childhood-and-pregnancy-screening#bootstrap-panel--6

Finally, the organization, Safer Chemicals, Healthy Families, recommends a combined strategy of universal lead screening of younger children and intensive education outreach for health care providers and parents.[lxv] According to this organization, focused program attention on specific geographical areas of lead poisoning concern, such as tracks with older housing stock, neighborhoods with elevated lead levels in drinking water, and housing near contaminated industrial sites, is justified. These are same the factors that determine the emphasis in state-targeted lead screening programs.

FINANCIAL IMPACT

In assessing the financial impact of the proposed lead screening legislation, the Mandated Health Benefits Advisory Commission is limited by the absence of a fiscal note on this bill by New Jersey's Office of Legislative Services. Furthermore, since no other state has proposed a comparable bill for lead screening of children up to the age of 16, there are no other state models of such a bill's financial impact.

Federal insurance mandates for screening procedures, through the Affordable Care Act, are tied to the recommendations of the US Preventive Services Task Force (USPSTF). USPSTF's most recent recommendations do not report finding sufficient empirical evidence to justify universal testing of children, even young children.[lxvi]

This proposed legislation includes both a practice mandate that all providers and facilities screen children up to age 16, as well as a coverage mandate that requires some, but not all, insurers to expand coverage for lead screenings up to age 16. The result is that the practice mandate is broader than the coverage mandate. The scope of the insurance coverage mandate is limited to state-regulated insurance markets, excluding Medicaid, self-funded plans, the State Health Benefits Plan, the School Employees' Health Benefits Program, and other plans not regulated by the state.

The MHBAC estimates that the proposed insurance mandate would cover about 15% of New Jersey residents. To a certain extent, this incongruity between the practice and the insurance coverage mandate may exist even under the current coverage mandate up to age 6. However, since it is common for states, self-funded plans, and Medicaid to cover lead screening at younger ages, a shift in New Jersey to lead screening for children up to age 16 would mean New Jersey is an outlier and many children between the ages of 6 and 16 will be screened for lead, as the practice mandate requires, but may not have the testing covered by their health coverage plan. This could leave such patients with self-pay expenses for mandated lead screening or could require providers to provide services without compensation.

CONCLUSION

Balancing Social Impact, Medical Evidence, and Financial Impact

Lead poisoning in young children causes developmental harm and results in a number of deleterious outcomes. Exposure to elevated lead levels in children can result in slowed growth, decreased ability to concentrate, hyperactivity, cognitive deficits, and lowered academic achievement. Elimination or remediation of lead exposure in younger, developing children is and should be a policy priority.

The empirical evidence for testing all younger children is mixed, resulting in a range of lead screening policies across the 50 states. Some states mandate universal screening of all very young children at several ages. Other states target blood testing of some children deemed to be at particular risk of lead poisoning. Some states follow federal Medicaid policy, but have no additional lead screening policy recommendations at all. No state has passed legislation mandating universal testing of children above the age of 6, nor has the MHBAC identified any studies that provide the financial justification for such a mandate.

ENDNOTES

[i] US Preventive Services Task Force, "Elevated Blood Lead Levels in Children and Pregnant Women: Screening," April 16, 2019. (https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/elevated-blood-lead-levels-in-childhood-and-pregnancy-screening)

[ii] See, *e.g.*, N.J.S.A.17:48E-35.10, which requires coverage, in part, for: "Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health 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."

[iii] Price, D. (Ed). The Toxic Truth: Children's Exposure to Lead Pollution Undermines a Generation of Future Potential. UNICEF and Pure Earth, July 2020. (https://www.unicef.org/reports/toxic-truth-childrens-exposure-to-lead-pollution-2020)

[iv] Center for Disease Control and Prevention (CDC#1): Childhood Lead Poisoning Fact Sheet. April 2013. (https://www.cdc.gov/nceh/lead/prevention/blood-lead-levels.htm)

[v] Dignan, T., Kaufmann, R., LeStourgeon, L., and Brown, M.J. Lead Poisoning Prevention. J Public Health Manag Pract. (Suppl 1). Jan-Feb 2019; 25: S13–22.doi: 10.1097/PHH.0000000000000889 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6522252/)

[vi] Hauptman, M., Bruccoleri, R., and Woolf, A. An Update on Childhood Lead Poisoning. Clin Pediatr Emerg Med. September 2017; 18(3): 181–192.doi: 10.1016/j.cpem.2017.07.010 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5645046/)

[vii] New Jersey Department of Health. Childhood Lead Exposure in New Jersey. Annual Report. New Jersey Department of Health, Office of Local Public Health, Childhood Lead Program, June 2018. (https://www.state.nj.us/health/childhoodlead/data.shtml)

[viii] Geoscience News and Information/Geology.com. Galena. Accessed 10/26/20 at (https://geology.com/minerals/galena.shtml)

[ix] Royal Society for Chemistry (RSC). Lead. 2020. Accessed 5/27/20 at (https://www.rsc.org/periodic-table/element/82/lead#:~:text=Lead%20is%20still%20widely%20used,used%20to%20store%20corrosive%20liquids)

[x] Crow, J.M. "Why use lead in paint?" Chemistry World, August 21, 2007. Accessed 10/27/20 at (https://www.chemistryworld.com/news/why-use-lead-in-paint/3004319.article#/)

[xi] Riva, M., Lafranconi, A., D'Orso, M., and Cesana, G. Lead Poisoning: Historical Aspects of a Paradigmatic "Occupational and Environmental Disease. Safe Health Work. March 2012, Vol. 3(1): 11-16. Accessed 10/27/20 at (https://bit.ly/34DdXwB)

[xii] *Ibid.*

[xiii] Case Western Reserve University. "Leaded gasoline predominant source of lead exposure in latter 20th century." ScienceDaily. ScienceDaily, 15 June 2010. Accessed 10/28/20 at (www.sciencedaily.com/releases/2010/06/100615141757.htm)

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ASSEMBLY, No. 1673

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:
Assemblywoman ANNETTE QUIJANO
District 20 (Union)
Assemblywoman VERLINA REYNOLDS-JACKSON
District 15 (Hunterdon and Mercer)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)

Co-Sponsored by:
Assemblywoman Downey and Assemblyman Houghtaling

SYNOPSIS

Requires health insurance companies to cover lead screenings for children 16 years of age or younger.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning health insurance coverage for lead screenings for children 16 years of age or , amending P.L.1995, c.316 and P.L.1995, c.328.

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

1. Section 7 of P.L.1995, c.316 (26:2-137.1) is amended to read as follows:

7. The Department of Health shall specify by regulation, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.):

a. The lead screening requirements provided for under P.L.1995, c.316 (C.17:48E-35.10 et al.), including the age of the child when initial screening should be conducted, the time intervals between screening, when follow-up testing is required, the methods that shall be used to conduct the lead screening, and, in accordance with the latest recommendations of the federal Centers for Disease Control and Prevention and the provisions of P.L.1995, c.328 (C.26:2-137.2 et seq.), the level of lead in the bloodstream that shall necessitate the undertaking of responsive action. Any regulations adopted pursuant to this subsection shall be consistent with the provisions of P.L.1995, c.328 (26:2-137.2 et seq.); and

b. The childhood immunizations recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health.

(cf: P.L.2017, c.7, s.2)

2. Section 3 of P.L.1995, c.328 (C.26:2-137.4) is amended to read as follows:

3. a. A physician or registered professional nurse, as appropriate, shall perform lead screening on each patient **[**under six**]** 16 years of age or younger to whom the physician or registered professional nurse provides health care services, unless the physician or registered professional nurse has knowledge that the child has already undergone lead screening in accordance with the requirements of this act. If the physician, registered professional nurse, or an authorized staff member cannot perform the required lead screening, the physician or registered professional nurse may refer the patient, in writing, to another physician, registered professional nurse, health care facility, or designated agency or program which is able to perform the lead screening.

b. A health care facility that serves children and is licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), and any other agency or program that serves children and is designated by the commissioner to perform lead screening, shall perform lead screening on each child **[**under six**]** 16 years of age or younger that

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

Matter underlined thus is new matter.

the facility, agency, or program serves, unless the facility, agency, or program has knowledge that the child has already undergone lead screening in accordance with the requirements of this act. If the health care facility, agency, or program cannot perform the required lead screening, the facility, agency, or program may refer the patient, in writing, to another health care facility, physician, registered professional nurse, or other designated agency or program which is able to perform the lead screening.

c. If a physician, registered professional nurse, or health care facility, agency, or program receives laboratory test results indicating that a child has an elevated blood lead level, the physician, registered professional nurse, or health care facility, agency, or program shall notify the parent or guardian of the child, in writing, about the test results, and shall additionally provide the parent or guardian with an explanation, in plain language, of the significance of lead poisoning. The physician, registered professional nurse, or health care facility, agency, or program shall also take appropriate measures to ensure that any of the child's siblings or other members of the household who are **[**under the age of six**]** 16 years of age or younger either are, or have been, screened for lead exposure.

d. A physician, registered professional nurse, or health care facility, agency, or program shall not be required to conduct lead screening under this act if the parent or guardian of the child objects to the testing in writing.

e. (1) The department shall specify, by regulation, the parameters for lead screening required under this act, including the age of the child when initial screening shall be conducted, the time intervals between screening, when follow-up testing is required, and the methods that shall be used to conduct the lead screening.

(2) (a) The department shall additionally specify, by regulation, in accordance with the most recent recommendations of the federal Centers for Disease Control and Prevention, the elevated blood lead levels that require responsive action under this act, and the types of responsive action, including environmental follow-up, notice to the family, additional screening of family members, the provision of case management services, and the provision of medical treatment such as chelation therapy, that shall be undertaken when a screening test reveals an elevated blood lead level. The levels of responsive action required by the department pursuant to this paragraph may vary, consistent with the latest recommendations of the federal Centers for Disease Control and Prevention, based on the severity of the elevated blood lead level.

(b) Within 30 days after the enactment of P.L.2017, c.7, and on a biennial basis thereafter, the department shall review and appropriately revise its rules and regulations pertaining to elevated blood lead levels, in order to ensure that they appropriately reflect,

and are consistent with, the latest guidance from the federal Centers for Disease Control and Prevention.

f. The department shall develop a mechanism, such as distribution of lead screening record cards or other appropriate means, by which children who have undergone lead screening can be identified by physicians, registered professional nurses, and health care facilities, agencies, and programs that perform lead screening, so as to avoid duplicate lead screening of children.

g. The department shall continuously engage in a public information campaign to inform the parents of young children, as well as physicians, registered professional nurses, and other health care providers, of the lead screening requirements of this act. At a minimum, the public information campaign shall: (1) highlight the importance of lead screening, and encourage parents, especially those who have not yet complied with the lead screening provisions of this act, to have their children screened for lead poisoning at regular intervals, in accordance with the age-based timeframes established by department regulation; and (2) provide for the widespread dissemination of information to parents and health care providers on the dangers of lead poisoning, the factors that contribute to lead poisoning, the recommended ages at which children should be tested for lead poisoning, and the elevated blood lead levels that require responsive action under this act. If the department changes the elevated blood lead levels that require responsive action under this act, as may be necessary to conform its regulations to federal guidance, the information disseminated through the public information campaign shall be appropriately revised to reflect the new action levels, and shall be reissued to parents and health care providers, within 30 days after the change is implemented.

h. The department, to the greatest extent possible, shall coordinate payment for lead screening required pursuant to this act with the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) and other federal children's health programs, so as to ensure that the State receives the maximum amount of federal financial participation available for the lead screening services provided pursuant to this act.

(cf: P.L.2017, c.7, s.5.)

3. This act shall take effect on the 90th day after the date of enactment.

STATEMENT

This bill requires health insurance companies to cover lead screenings for children 16 years of age or younger. Under current law, health insurance companies are only required to cover

screenings by blood lead measurement for children under the age of six.

This bill will help protect the children of New Jersey from the harms of lead poisoning and elevated blood lead levels. There is no safe level of lead exposure in children, as even low levels of lead in the bloodstream can stunt a child's development. By requiring health insurance companies to cover lead screenings in children who are 16 years of age or younger, the State will be taking a substantial step to detect lead exposure in children before it is too late.

NEW JERSEY GENERAL ASSEMBLY

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COMMITTEES
MEMBER
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APPROPRIATIONS
ENVIRONMENT AND SOLID WASTE
INTERGOVERNMENTAL RELATIONS COMMISSION

September 29, 2020

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, NJ 08625

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institution and Insurance Committee, I respectfully request the Commission to review and prepare a written report of A-1673, sponsored by Assemblywoman Annette Quijano. The bill would require health insurance companies to cover lead screenings for children 16 years of age or younger.

If you have any questions, please do not hesitate to contact, Mark Iaconelli, Assembly Financial Institutions and Insurance Committee Aide, at 609-847-3500. Thank you for your immediate attention to this matter.

Very truly yours,

John F. McKeon, Esq.

CC: Hon. Annette Quijano, Majority Conference Leader
Mark Iaconelli, Jr., Esq., Committee Aide