§1 - C.17:48-6tt
§2 - C.17:48A-7qq
§3 - C.17:48E-35.44
§4 - C.17B:26-2.1mm
§5 - C.17B:27-46.1tt
§6 - C.17B:27A-7.27
§7 - C.17B:27A-19.31
§8 - C.26:2J-4.45
§9 - C.52:14-17.29dd
§10 - C.52:14-17.46.6o
§11 - Note

(CORRECTED COPY)

P.L. 2019, CHAPTER 360, ***approved January 16, 2020***

Assembly, No. 5507 ***(First Reprint)***

1 **AN ACT** concerning insurance coverage for preventive services and
2 supplementing various parts of the statutory law.
3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*
6
7 1. a. A hospital service corporation contract that provides
8 hospital or medical expense benefits and is delivered, issued,
9 executed or renewed in this State, or approved for issuance or
10 renewal in this State by the Commissioner of Banking and
11 Insurance, on or after the effective date of this act, shall provide
12 coverage, without requiring any cost sharing, for the following
13 preventive services:
14 (1) evidence-based items or services that have in effect a rating
15 of "A" or "B" in the current recommendations of the United States
16 Preventive Services Task Force;
17 (2) immunizations that have in effect a recommendation from
18 the Advisory Committee on Immunization Practices of the Centers
19 for Disease Control and Prevention;
20 (3) with respect to infants, children, and adolescents, evidence-
21 informed preventive care and screenings provided for in the
22 comprehensive guidelines supported by the Health Resources and
23 Services Administration; and
24 (4) with respect to women, any additional preventive care and
25 screenings not described in paragraph (1) as provided for in the
26 comprehensive guidelines supported by the Health Resources and
27 Services Administration.
28 b. [1]<u>(1) Except as provided in paragraph (2) of this subsection,</u>
29 <u>nothing in this section shall:</u>

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SBA committee amendments adopted January 6, 2020.

(a) require a contract which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a contract which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a contract does not have in its network a provider who can provide an item or service described in subsection a. of this section, the contract shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A contract shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a contract that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] The provisions of this section shall apply to those hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

2. a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the

1 comprehensive guidelines supported by the Health Resources and
2 Services Administration.
3 b. [1](1) Except as provided in paragraph (2) of this subsection,
4 nothing in this section shall:
5 (a) require a contract which has a network of providers to provide
6 benefits for items or services described in subsection a. of this section
7 that are delivered by an out-of-network provider; or
8 (b) preclude a contract which has a network of providers from
9 imposing cost-sharing requirements for items or services described in
10 subsection a. of this section that are delivered by an out-of-network
11 provider.
12 (2) If a contract does not have in its network a provider who can
13 provide an item or service described in subsection a. of this section,
14 the contract shall cover the item or service when performed by an out-
15 of-network provider, and shall not impose cost sharing with respect to
16 that item or service.
17 c. (1) A contract shall provide coverage for an item or service
18 described in subsection a. of this section for plan years that begin on or
19 after the date that is one year after the date the recommendation or
20 guideline is issued.
21 (2) (a) Except as provided in subparagraph (b) of this paragraph, a
22 contract that is required to provide coverage for an item or service
23 described in subsection a. of this section on the first day of a plan year
24 shall provide coverage for that item or service through the last day of
25 the plan year.
26 (b) The commissioner may remove a coverage requirement for an
27 item or service during a plan year if the recommendation or guideline
28 changes or is no longer described in subsection a. of this section.
29 d.[1] The provisions of this section shall apply to those medical
30 service corporation contracts in which the medical service
31 corporation has reserved the right to change the premium.
32
33 3. a. A health service corporation contract that provides
34 hospital or medical expense benefits and is delivered, issued,
35 executed or renewed in this State, or approved for issuance or
36 renewal in this State by the Commissioner of Banking and
37 Insurance, on or after the effective date of this act, shall provide
38 coverage, without requiring any cost sharing, for the following
39 preventive services:
40 (1) evidence-based items or services that have in effect a rating
41 of "A" or "B" in the current recommendations of the United States
42 Preventive Services Task Force;
43 (2) immunizations that have in effect a recommendation from
44 the Advisory Committee on Immunization Practices of the Centers
45 for Disease Control and Prevention;
46 (3) with respect to infants, children, and adolescents, evidence-
47 informed preventive care and screenings provided for in the

comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

b. [1](1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a contract which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a contract which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a contract does not have in its network a provider who can provide an item or service described in subsection a. of this section, the contract shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A contract shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a contract that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] The provisions of this section shall apply to those health service corporation contracts in which the health service corporation has reserved the right to change the premium.

4. a. An individual health insurer policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

b. [1](1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a policy which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a policy which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a policy does not have in its network a provider who can provide an item or service described in subsection a. of this section, the policy shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A policy shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a policy that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] This section shall apply to those policies in which the insurer has reserved the right to change the premium.

5. a. A group health insurer policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

1 (2) immunizations that have in effect a recommendation from
2 the Advisory Committee on Immunization Practices of the Centers
3 for Disease Control and Prevention;
4 (3) with respect to infants, children, and adolescents, evidence-
5 informed preventive care and screenings provided for in the
6 comprehensive guidelines supported by the Health Resources and
7 Services Administration; and
8 (4) with respect to women, any additional preventive care and
9 screenings not described in paragraph (1) as provided for in the
10 comprehensive guidelines supported by the Health Resources and
11 Services Administration.
12 b. [1](1) Except as provided in paragraph (2) of this subsection,
13 nothing in this section shall:
14 (a) require a policy which has a network of providers to provide
15 benefits for items or services described in subsection a. of this section
16 that are delivered by an out-of-network provider; or
17 (b) preclude a policy which has a network of providers from
18 imposing cost-sharing requirements for items or services described in
19 subsection a. of this section that are delivered by an out-of-network
20 provider.
21 (2) If a policy does not have in its network a provider who can
22 provide an item or service described in subsection a. of this section,
23 the policy shall cover the item or service when performed by an out-
24 of-network provider, and shall not impose cost sharing with respect to
25 that item or service.
26 c. (1) A policy shall provide coverage for an item or service
27 described in subsection a. of this section for plan years that begin on or
28 after the date that is one year after the date the recommendation or
29 guideline is issued.
30 (2) (a) Except as provided in subparagraph (b) of this paragraph, a
31 policy that is required to provide coverage for an item or service
32 described in subsection a. of this section on the first day of a plan year
33 shall provide coverage for that item or service through the last day of
34 the plan year.
35 (b) The commissioner may remove a coverage requirement for an
36 item or service during a plan year if the recommendation or guideline
37 changes or is no longer described in subsection a. of this section.
38 d.[1] This section shall apply to those policies in which the insurer
39 has reserved the right to change the premium.
40
41 6. a. An individual health benefits plan that provides hospital
42 or medical expense benefits and is delivered, issued, executed or
43 renewed in this State, or approved for issuance or renewal in this
44 State by the Commissioner of Banking and Insurance, on or after
45 the effective date of this act, shall provide coverage, without
46 requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

b. [1](1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a plan which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a plan which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a plan does not have in its network a provider who can provide an item or service described in subsection a. of this section, the plan shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A plan shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a plan that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] This section shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

7. a. An small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and

Insurance, on or after the effective date of this act, shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

b. [1](1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a plan which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a plan which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a plan does not have in its network a provider who can provide an item or service described in subsection a. of this section, the plan shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A plan shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a plan that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

8. a. A health maintenance organization contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

b. [1](1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a contract which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a contract which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a contract does not have in its network a provider who can provide an item or service described in subsection a. of this section, the contract shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A contract shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a contract that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.

d.[1] The provisions of this section shall apply to those contracts in which the health maintenance organization has reserved the right to change the premium.

9. [1]a.[1] The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

[1]b. (1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a contract which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a contract which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a contract does not have in its network a provider who can provide an item or service described in subsection a. of this section, the contract shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A contract shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a contract that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

(b) The commissioner may remove a coverage requirement for an item or service during a plan year if the recommendation or guideline changes or is no longer described in subsection a. of this section.[1]

10. [1]a.[1] The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage, without requiring any cost sharing, for the following preventive services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, any additional preventive care and screenings not described in paragraph (1) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

[1]b. (1) Except as provided in paragraph (2) of this subsection, nothing in this section shall:

(a) require a contract which has a network of providers to provide benefits for items or services described in subsection a. of this section that are delivered by an out-of-network provider; or

(b) preclude a contract which has a network of providers from imposing cost-sharing requirements for items or services described in subsection a. of this section that are delivered by an out-of-network provider.

(2) If a contract does not have in its network a provider who can provide an item or service described in subsection a. of this section, the contract shall cover the item or service when performed by an out-of-network provider, and shall not impose cost sharing with respect to that item or service.

c. (1) A contract shall provide coverage for an item or service described in subsection a. of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) (a) Except as provided in subparagraph (b) of this paragraph, a contract that is required to provide coverage for an item or service described in subsection a. of this section on the first day of a plan year shall provide coverage for that item or service through the last day of the plan year.

1 (b) The commissioner may remove a coverage requirement for an
2 item or service during a plan year if the recommendation or guideline
3 changes or is no longer described in subsection a. of this section.[1]
4
5 11. This act shall take effect on the 90th day next following
6 enactment and shall apply to policies or contracts issued or renewed
7 on or after the effective date.
8
9
10 ________________
11
12 Requires health benefits coverage for certain preventive services.