[First Reprint]

ASSEMBLY, No. 5507

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED JUNE 6, 2019

Sponsored by:
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District 27 (Essex and Morris)
Assemblyman HERB CONAWAY, JR.
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District 35 (Bergen and Passaic)
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District 29 (Essex)

Co-Sponsored by:
Assemblywoman Speight, Assemblyman Caputo, Assemblywomen Vainieri Huttle, Lampitt, Jasey, McKnight, Downey, Senators Lagana and Greenstein

SYNOPSIS

Requires health benefits coverage for certain preventive services.

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on January 6, 2020, with amendments.

(Sponsorship Updated As Of: 1/14/2020)

AN ACT concerning insurance coverage for preventive services and supplementing various parts of the statutory law.

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

1. a. A hospital 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 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.

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

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

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

1 c. (1) A contract shall provide coverage for an item or service
2 described in subsection a. of this section for plan years that begin on or
3 after the date that is one year after the date the recommendation or
4 guideline is issued.
5 (2) (a) Except as provided in subparagraph (b) of this paragraph, a
6 contract that is required to provide coverage for an item or service
7 described in subsection a. of this section on the first day of a plan year
8 shall provide coverage for that item or service through the last day of
9 the plan year.
10 (b) The commissioner may remove a coverage requirement for an
11 item or service during a plan year if the recommendation or guideline
12 changes or is no longer described in subsection a. of this section.
13 d.[1] The provisions of this section shall apply to those medical
14 service corporation contracts in which the medical service
15 corporation has reserved the right to change the premium.
16
17 3. a. A health service corporation contract that provides
18 hospital or medical expense benefits and is delivered, issued,
19 executed or renewed in this State, or approved for issuance or
20 renewal in this State by the Commissioner of Banking and
21 Insurance, on or after the effective date of this act, shall provide
22 coverage, without requiring any cost sharing, for the following
23 preventive services:
24 (1) evidence-based items or services that have in effect a rating
25 of "A" or "B" in the current recommendations of the United States
26 Preventive Services Task Force;
27 (2) immunizations that have in effect a recommendation from
28 the Advisory Committee on Immunization Practices of the Centers
29 for Disease Control and Prevention;
30 (3) with respect to infants, children, and adolescents, evidence-
31 informed preventive care and screenings provided for in the
32 comprehensive guidelines supported by the Health Resources and
33 Services Administration; and
34 (4) with respect to women, any additional preventive care and
35 screenings not described in paragraph (1) as provided for in the
36 comprehensive guidelines supported by the Health Resources and
37 Services Administration.
38 b. [1](1) Except as provided in paragraph (2) of this subsection,
39 nothing in this section shall:
40 (a) require a contract which has a network of providers to provide
41 benefits for items or services described in subsection a. of this section
42 that are delivered by an out-of-network provider; or
43 (b) preclude a contract which has a network of providers from
44 imposing cost-sharing requirements for items or services described in
45 subsection a. of this section that are delivered by an out-of-network
46 provider.
47 (2) If a contract does not have in its network a provider who can
48 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.

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

6. a. An individual 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 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

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 contracts
30 in which the health maintenance organization has reserved the right
31 to change the premium.
32
33 9. [1]a.[1] The State Health Benefits Commission shall ensure that
34 every contract purchased by the commission on or after the
35 effective date of this act that provides hospital or medical expense
36 benefits shall provide coverage, without requiring any cost sharing,
37 for the following preventive services:
38 (1) evidence-based items or services that have in effect a rating
39 of "A" or "B" in the current recommendations of the United States
40 Preventive Services Task Force;
41 (2) immunizations that have in effect a recommendation from
42 the Advisory Committee on Immunization Practices of the Centers
43 for Disease Control and Prevention;
44 (3) with respect to infants, children, and adolescents, evidence-
45 informed preventive care and screenings provided for in the
46 comprehensive guidelines supported by the Health Resources and
47 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.

(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]

11. This act shall take effect on the 90th day next following enactment and shall apply to policies or contracts issued or renewed on or after the effective date.