

## CHAPTER 360

**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:

C.17:48-6tt Hospital service corporation to cover preventive services.

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) 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. 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.

C.17:48A-7qq Medical service corporation to cover preventive services.

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 comprehensive guidelines supported by the Health Resources and Services Administration.

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.

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

C.17:48E-35.44 Health service corporation to cover preventive services.

3. a. A health 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) 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. 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.

C.17B:26-2.1mm Individual health insurer policy to cover preventive services.

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) 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. This section shall apply to those policies in which the insurer has reserved the right to change the premium.

C.17B:27-46.1tt Group health insurer policy to cover preventive services.

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;

(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) 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. This section shall apply to those policies in which the insurer has reserved the right to change the premium.

C.17B:27A-7.27 Individual health benefits plan to cover preventive services.

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

C.17B:27A-19.31 Small employer health benefits plan to cover preventive services.

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

C.26:2J-4.45 Health maintenance organization to cover preventive services.

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

C.52:14-17.29dd SHBC to cover preventive services.

9. a. 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.

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.

C.52:14-17.46.6o School Employee's Health Benefits Commission to cover preventive services.

10. a. 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.

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.

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.

Approved January 16, 2020.