

ASSEMBLY, No. 2215

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Assemblyman JOHN F. MCKEON

District 27 (Essex and Morris)

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Co-Sponsored by:

**Assemblywoman Speight, Assemblyman Caputo, Assemblywomen Vainieri
Huttle, Lampitt, Jasey and McKnight**

SYNOPSIS

Requires health benefits coverage for certain preventive services.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



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) Except as provided in paragraph (2) of this subsection,
29 nothing in this section shall:

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

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

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

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

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

1 shall provide coverage for that item or service through the last day of
2 the plan year.

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

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

9
10 2. a. A medical service corporation contract that provides
11 hospital or medical expense benefits and is delivered, issued,
12 executed or renewed in this State, or approved for issuance or
13 renewal in this State by the Commissioner of Banking and
14 Insurance, on or after the effective date of this act, shall provide
15 coverage, without requiring any cost sharing, for the following
16 preventive services:

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

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

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

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

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

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

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

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

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

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

12
13 3. a. A health 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) 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. The provisions of this section shall apply to those health
14 service corporation contracts in which the health service
15 corporation has reserved the right to change the premium.

16

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

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

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

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

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

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

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

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

46 (2) If a policy does not have in its network a provider who can
47 provide an item or service described in subsection a. of this section,
48 the policy shall cover the item or service when performed by an out-

1 of-network provider, and shall not impose cost sharing with respect to
2 that item or service.

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

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

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

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

17
18 5. a. A group health insurer policy that provides hospital or
19 medical expense benefits and is delivered, issued, executed or
20 renewed in this State, or approved for issuance or renewal in this
21 State by the Commissioner of Banking and Insurance, on or after
22 the effective date of this act, shall provide coverage, without
23 requiring any cost sharing, for the following 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) Except as provided in paragraph (2) of this subsection,
39 nothing in this section shall:

40 (a) require a policy 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 policy 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 policy does not have in its network a provider who can
48 provide an item or service described in subsection a. of this section,

1 the policy shall cover the item or service when performed by an out-
2 of-network provider, and shall not impose cost sharing with respect to
3 that item or service.

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

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

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

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

18
19 6. a. An individual health benefits plan that provides hospital
20 or medical expense benefits and is delivered, issued, executed or
21 renewed in this State, or approved for issuance or renewal in this
22 State by the Commissioner of Banking and Insurance, on or after
23 the effective date of this act, shall provide coverage, without
24 requiring any cost sharing, for the following preventive services:

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

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

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

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

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

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

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

1 (2) If a plan 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 plan shall cover the item or service when performed by an out-of-
4 network provider, and shall not impose cost sharing with respect to
5 that item or service.

6 c. (1) A plan 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 plan 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. This section shall apply to all individual health benefits
19 plans in which the carrier has reserved the right to change the
20 premium.

21
22 7. a. An small employer health benefits plan that provides
23 hospital or medical expense benefits and is delivered, issued,
24 executed or renewed in this State, or approved for issuance or
25 renewal in this State by the Commissioner of Banking and
26 Insurance, on or after the effective date of this act, shall provide
27 coverage, without requiring any cost sharing, for the following
28 preventive services:

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

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

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

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

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

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

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

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

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

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

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

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

25
26 8. a. A health maintenance organization contract that provides
27 hospital or medical expense benefits and is delivered, issued,
28 executed or renewed in this State, or approved for issuance or
29 renewal in this State by the Commissioner of Banking and
30 Insurance, on or after the effective date of this act, shall provide
31 coverage, without requiring any cost sharing, for the following
32 preventive services:

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

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

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

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

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

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

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

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

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

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

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

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

28
29 9. a. The State Health Benefits Commission shall ensure that
30 every contract purchased by the commission on or after the
31 effective date of this act that provides hospital or medical expense
32 benefits shall provide coverage, without requiring any cost sharing,
33 for the following preventive services:

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

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

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

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

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

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

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

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

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

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

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

27
28 10. a. The School Employees' Health Benefits Commission shall
29 ensure that every contract purchased by the commission on or after
30 the effective date of this act that provides hospital or medical
31 expense benefits shall provide coverage, without requiring any cost
32 sharing, for the following preventive services:

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

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

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

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

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

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

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

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

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

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

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

25
26 11. This act shall take effect on the 90th day next following
27 enactment and shall apply to policies or contracts issued or renewed
28 on or after the effective date.

29
30
31 STATEMENT

32
33 This bill requires health insurers (health, hospital and medical
34 service corporations, commercial individual and group health insurers;
35 health maintenance organizations, health benefits plans issued
36 pursuant to the New Jersey Individual Health Coverage and Small
37 Employer Health Benefits Programs, the State Health Benefits
38 Program, and the School Employees' Health Benefits Program) to
39 provide coverage, without requiring any cost sharing, for expenses
40 incurred in the provision of the following preventive services:

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

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

47 (3) with respect to infants, children, and adolescents, evidence-
48 informed preventive care and screenings provided for in the

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

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

7 The bill provides that health insurer contracts which have a network
8 of providers to provide benefits for preventive services are not
9 required to pay for, and may impose cost-sharing requirements on,
10 services that are delivered by out-of-network providers.

11 If a contract does not have in its network a provider who can
12 provide a preventive service described under the bill, the contract is
13 required to cover the service when performed by an out-of-network
14 provider, and may not impose cost sharing with respect to that service.

15 The bill provides that a health insurer contract must provide
16 coverage for preventive services for plan years that begin on or after
17 the date that is one year after the date the recommendation or guideline
18 is issued. A contract that is required to provide coverage for
19 preventive services on the first day of a plan year must provide
20 coverage for that item or service through the last day of the plan year,
21 except that the commissioner may remove a coverage requirement for
22 a preventive service during a plan year if the recommendation or
23 guideline changes or is removed.

WITHDRAWN