

CHAPTER 283

AN ACT concerning insurance and State Medicaid coverage for immunizations and the Advisory Committee on Immunization Practices and amending various parts of the statutory law.

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

1. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read as follows:

C.17:48-6m Hospital service corporation contracts, child screening, blood lead, hearing loss; immunizations.

2. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be 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 P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A hospital service corporation shall notify its subscribers, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 6 of P.L.2005, c.248 (C.17:48-6dd). This section shall apply to all hospital service corporation contracts in which the health service corporation has reserved the right to change the premium.

2. Section 1 of P.L.2019, c.360 (C.17:48-6tt) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

3. Section 3 of P.L.2019, c.360 (C.17:48E-35.44) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

4. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to read as follows:

C.17:48E-35.10 Health service corporation contracts, child screening, blood lead, hearing loss; immunizations.

1. No health service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be 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 P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A health service corporation shall notify its subscribers, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. The notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 3 of P.L.2005, c.248 (C.17:48E-35.28). This section shall apply to all health service corporation contracts in which the health service corporation has reserved the right to change the premium.

5. Section 2 of P.L.2019, c.360 (C.17:48A-7qq) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

6. Section 4 of P.L.2019, c.360 (C.17B:26-2.1mm) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

7. Section 5 of P.L.2019, c.360 (C.17B:27-46.1tt) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

8. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) is amended to read as follows:

C.17B:27-46.11 Group health insurance policy, child screening, blood lead, hearing loss; immunizations.

3. No group health insurance policy providing hospital or medical expense benefits for groups with more than 50 persons shall be 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 P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A health insurer shall notify its policyholders, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the policy, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a policy that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 9 of P.L.2005, c.248 (C.17B:27-46.1dd). This section shall apply to all group health insurance policies in which the health insurer has reserved the right to change the premium.

9. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read as follows:

C.17B:27A-7 Approval of policy and contract forms, benefit levels.

6. The commissioner shall approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The commissioner shall provide the board with an informational filing of the policy and contract forms and benefit levels it approves.

a. The individual health benefits plans established by the board may include cost containment measures such as, but not limited to: utilization review of health care services, including review of medical necessity of hospital and physician services; case management benefit alternatives; selective contracting with hospitals, physicians, and other health care providers; reasonable benefit differentials applicable to participating and nonparticipating providers; and other managed care provisions.

b. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting condition limitation of any period and shall not include a preexisting condition as a factor in calculating the premium.

c. In addition to the standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).

d. After the board's establishment of the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the commissioner and certify to the commissioner that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the commissioner of the certification, the certified plans may be used until the commissioner, after notice and hearing, disapproves their continued use.

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

(2) All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A carrier shall notify its insureds, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005,

c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

The benefits shall be provided to the same extent as for any other prescribed items under the health benefits plan.

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

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

10. Section 6 of P.L.2019, c.360 (C.17B:27A-7.27) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family

Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

11. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to read as follows:

C.17B:27A-19 Health benefits plans offered to small employers; exceptions.

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer at least three of the health benefit plans established by the board, as provided in this section. The board shall establish a standard policy form for each of the plans, which except as otherwise provided in subsection j. of this section, shall be the only plans offered to small groups on or after January 1, 1994. One policy form shall contain the benefits provided for in sections 55, 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity carriers, one policy form shall be established which contains benefits and cost-sharing levels which are equivalent to the health benefits plans of health maintenance organizations pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

- (3) Diagnostic tests, including X-rays;
- (4) Maternity benefits, including prenatal and postnatal care; and
- (5) Preventive medicine, including periodic physical examinations and inoculations.

At least three of the forms shall provide for major medical benefits in varying lifetime aggregates, one of which shall provide at least \$1,000,000 in lifetime aggregate benefits. The policy forms provided pursuant to this section shall contain benefits representing progressively greater actuarial values.

Notwithstanding the provisions of this subsection to the contrary, the board also may establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits or health maintenance organization enrollees by direct contract with the enrollees' small employer through a dual arrangement with the health maintenance organization. The dual arrangement shall be filed with the commissioner for approval. The additional policy forms shall be consistent with the general requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).

b. Initially, a carrier shall offer a plan within 90 days of the approval of such plan by the commissioner. Thereafter, the plans shall be available to all small employers on a continuing basis. Every small employer which elects to be covered under any health benefits plan who pays the premium therefor and who satisfies the participation requirements of the plan shall be issued a policy or contract by the carrier.

c. The carrier may establish a premium payment plan which provides installment payments and which may contain reasonable provisions to ensure payment security, provided that provisions to ensure payment security are uniformly applied.

d. In addition to the standard policies described in subsection a. of this section, the board may develop up to five rider packages. Any such package which a carrier chooses to offer shall be issued to a small employer who pays the premium therefor, and shall be subject to rating methodology set forth in section 9 of P.L.1992, c.162 (C.17B:27A-25).

e. (Deleted by amendment, P.L.2008, c.38).

f. Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the five plans required pursuant to this section.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is approved pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the plans required pursuant to this section, except that the plans shall provide the same level of benefits as required for a federally qualified health maintenance organization, including any requirements concerning copayments by enrollees.

g. A carrier shall not be required to own or control a health maintenance organization or otherwise affiliate with a health maintenance organization in order to comply with the provisions of this section, but the carrier shall be required to offer at least three of the benefits plans which are formulated by the board and approved by the commissioner, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.

h. Notwithstanding the provisions of subsection a. of this section to the contrary, the board may modify the benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3).

i. (1) In addition to the rider packages provided for in subsection d. of this section, every carrier may offer, in connection with the health benefits plans required to be offered by this section, any number of riders which may revise the coverage offered by the plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of a plan shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value of a plan shall be filed with the board for informational purposes before such rider may be sold. The added premium or reduction in premium for each rider, as applicable, shall be listed separately from the premium for the standard plan.

The commissioner shall disapprove any rider filed pursuant to this subsection that is unjust, unfair, inequitable, unreasonably discriminatory, misleading, or contrary to law or the public policy of this State. The commissioner shall not approve any rider which reduces benefits below those required by sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be sold pursuant to this section. The commissioner's determination shall be in writing and shall be appealable.

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 5, 7, 8, 9, and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

j. (1) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued by or through a carrier, association, or multiple employer arrangement prior to January 1, 1994 or, if the requirements of subparagraph (c) of paragraph (6) of this subsection are met, issued by or through an out-of-State trust prior to January 1, 1994, at the option of a small employer policy or contract holder, may be renewed or continued after February 28, 1994, or in the case of such a health benefits plan whose anniversary date occurred between March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated within 60 days of that anniversary date and renewed or continued if, beginning on the first 12-month anniversary date occurring on or after the sixtieth day after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of delivery of the health benefits plan, the health benefits plan renewed, continued, or reinstated pursuant to this subsection complies with the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9, and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

Nothing in this subsection shall be construed to require an association, multiple employer arrangement, or out-of-State trust to provide health benefits coverage to small employers that are not contemplated by the organizational documents, bylaws, or other regulations governing the purpose and operation of the association, multiple employer arrangement, or out-of-State trust. Notwithstanding the foregoing provision to the contrary, an association, multiple employer arrangement, or out-of-State trust that offers health benefits coverage to its members' employees and dependents:

(a) shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement, or out-of-State trust;

(b) shall not use actual or expected health status in determining its membership; and

(c) shall make available to its small employer members at least one of the standard benefits plans, as determined by the commissioner, in addition to any health benefits plan permitted to be renewed or continued pursuant to this subsection.

(2) Notwithstanding the provisions of this subsection to the contrary, a carrier or out-of-State trust which writes the health benefits plans required pursuant to subsection a. of this section shall be required to offer those plans to any small employer, association, or multiple employer arrangement.

(3) (a) A carrier, association, multiple employer arrangement, or out-of-State trust may withdraw a health benefits plan marketed to small employers that was in effect on December 31, 1993 with the approval of the commissioner. The commissioner shall approve a request to withdraw a plan, consistent with regulations adopted by the commissioner, only on the grounds that retention of the plan would cause an unreasonable financial burden to the issuing carrier, taking into account the rating provisions of section 9 of P.L.1992, c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

(b) A carrier which has renewed, continued, or reinstated a health benefits plan pursuant to this subsection that has not been newly issued to a new small employer group since January 1, 1994, may, upon approval of the commissioner, continue to establish its rates for that plan based on the loss experience of that plan if the carrier does not issue that health benefits plan to any new small employer groups.

(4) (Deleted by amendment, P.L.1995, c.340).

(5) A health benefits plan that otherwise conforms to the requirements of this subsection shall be deemed to be in compliance with this subsection, notwithstanding any change in the plan's deductible or copayment.

(6) (a) Except as otherwise provided in subparagraphs (b) and (c) of this paragraph, a health benefits plan renewed, continued, or reinstated pursuant to this subsection shall be filed with the commissioner for informational purposes within 30 days after its renewal date. No later than 60 days after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be amended to show any modifications in the plan that are necessary to comply with the provisions of this subsection. The commissioner shall monitor compliance of any such plan with the requirements of this subsection, except that the board shall enforce the loss ratio requirements.

(b) A health benefits plan filed with the commissioner pursuant to subparagraph (a) of this paragraph may be amended as to its benefit structure if the amendment does not reduce the actuarial value and benefits coverage of the health benefits plan below that of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. The amendment shall be filed with the commissioner for approval pursuant to the terms of sections 4, 8, 12, and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1, and N.J.S.17B:27-49, as applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

(c) A health benefits plan issued by a carrier through an out-of-State trust shall be permitted to be renewed or continued pursuant to paragraph (1) of this subsection upon approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that

is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.

(7) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, an association, multiple employer arrangement, or out-of-State trust may offer a health benefits plan authorized to be renewed, continued, or reinstated pursuant to this subsection to small employer groups that are otherwise eligible pursuant to paragraph (1) of subsection j. of this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued, or reinstated.

(8) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple employer arrangement, or out-of-State trust may offer coverage under a health benefits plan authorized to be renewed, continued, or reinstated pursuant to this subsection to new employees of small employer groups covered by the health benefits plan in accordance with the provisions of paragraph (1) of this subsection.

(9) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to the contrary, any individual, who is eligible for small employer coverage under a policy issued, renewed, continued, or reinstated pursuant to this subsection, but who would be subject to a preexisting condition exclusion under the small employer health benefits plan, or who is a member of a small employer group who has been denied coverage under the small employer group health benefits plan for health reasons, may elect to purchase or continue coverage under an individual health benefits plan until such time as the group health benefits plan covering the small employer group of which the individual is a member complies with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(10) In a case in which an association made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of P.L.1995, c.340, the new issuing carrier shall be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of this subsection.

(11) In a case in which an association, multiple employer arrangement, or out-of-State trust made available a health benefits plan on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

(12) In a case in which a small employer purchased a health benefits plan directly from a carrier on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

Notwithstanding the provisions of subparagraph (b) of paragraph (6) of this subsection to the contrary, a small employer who changes its health benefits plan's issuing carrier pursuant to the provisions of this paragraph, shall not, upon changing carriers, modify the benefit structure of that health benefits plan within six months of the date the issuing carrier was changed.

k. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to this section, including any plans offered by a State-approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section

7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

(2) All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A carrier shall notify its insureds, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a small employer health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 16 of P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

l. The board shall consider including benefits for speech-language pathology and audiology services, as rendered by speech-language pathologists and audiologists within the scope of their practices, in at least one of the standard policies and in at least one of the five riders to be developed under this section.

m. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to this section that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

The benefits shall be provided to the same extent as for any other prescribed items under the health benefits plan.

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

n. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of a small employer health benefits plan in effect on the effective date of P.L.2005, c.248

(C.17:48E-35.27 et al.), the health benefits plans required pursuant to this section that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plans offered by a State-approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network that represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this subsection. This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

12. Section 7 of P.L.2019, c.360 (C.17B:27A-19.31) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

13. Section 2 of P.L.2003, c.284 (C.18A:62-15.1) is amended to read as follows:

C.18A:62-15.1 Meningococcal disease immunizations for certain students.

2. a. Beginning in September 2004, a new student enrolling in a public or private institution of higher education in this State shall have received immunization for meningococcal disease as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians, as a condition of attendance at that institution, except as provided in section 3 of P.L.2003, c.284 (C.18A:62-15.2).

b. A student shall present evidence of the vaccination required pursuant to subsection a. of this section to the institution in a manner prescribed by the institution.

c. The Department of Health shall require each public or private institution of higher education in this State to offer the immunization required pursuant to subsection a. of this section to its students through the institution's student health services program or through a contractual agreement with a community health care provider.

d. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of subsections a., b., and c. of this section and section 3 of P.L.2003, c.284 (C.18A:62-15.2).

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

C.26:2-137.1 Specifications for lead screening of children, immunizations.

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

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

b. The childhood immunizations recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics,

the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians.

15. Section 1 of P.L.2019, c.330 (C.26:2H-18.79) is amended to read as follows:

C.26:2H-18.79 Influenza vaccination in health care facilities.

1. a. As used in this act:

"Commissioner" means the Commissioner of Health.

"Health care facility" means a general or special hospital, nursing home, or home health care agency licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

b. Commencing with the onset of the first influenza season next following the effective date of this act, each health care facility shall establish and implement an annual influenza vaccination program in accordance with the current recommendations of the Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians, and any rules and regulations adopted by the commissioner pursuant to this act.

c. For the purposes of its annual influenza vaccination program, each health care facility shall:

(1) annually provide an on-site or off-site influenza vaccination to each of its employees;

(2) require that each employee at the facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention, which vaccination shall be provided by the health care facility, except that an employee may, in lieu of receiving the influenza vaccination at the facility, present acceptable proof, comprising:

(a) an attestation from the employee, which shall be submitted in a form and manner designated by the facility, of a current influenza vaccination if the employee receives the vaccination from another vaccination source, which attestation shall include the lot number of the vaccination the employee received; or

(b) a medical exemption, which shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Department of Health. An attestation of a medical exemption shall be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards enumerated by the Department of Health;

(3) maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee and report to the Department of Health, in a manner and according to a schedule prescribed by the commissioner, the vaccination percentage rate of its workforce in receiving influenza vaccinations as part of the facility's annual vaccination program or by other means as attested to by the workforce, as applicable. The report may also include other information that the facility deems relevant to its vaccination percentage rate, including, but not limited to, the number of employees who received medical exemptions;

(4) provide an educational component to its program that is designed to inform employees about: influenza vaccination; non-vaccine influenza control measures; and the symptoms, transmission, and potential impact of influenza;

(5) annually conduct an evaluation of the program with the goal of improving the rate of vaccination among its employees; and

(6) require any employee who does not receive an influenza vaccination to wear a surgical or procedural mask when in direct contact with patients and in common areas, as specified in facility policy, or to be removed from direct patient care responsibilities during influenza season.

d. A health care facility may suspend its annual influenza vaccination program pursuant to this act in the event of a shortage of influenza vaccine as determined by the commissioner.

e. (1) The commissioner may assess such penalties and take other actions against a health care facility, as provided in P.L.1971, c.136 (C.26:2H-1 et seq.), or any rules and regulations adopted pursuant thereto, for any determination by the commissioner of noncompliance by a health care facility or any of its employees with the provisions of this act.

(2) The commissioner shall seek to minimize any record-keeping burden imposed on a health care facility pursuant to this act and shall take such actions as are necessary to ensure the confidentiality of any data furnished to the department pursuant to this act that may contain information identifying an individual employee.

(3) The commissioner shall make available to the public aggregate data reported by a facility pursuant to paragraph (3) of subsection c. of this section.

f. A health care facility shall not discharge or reduce the pay of an employee who receives a medical exemption from the annual influenza vaccination requirement.

g. Nothing in this section shall be construed to prohibit a health care facility from adopting additional policies and procedures with regard to the annual influenza vaccine that are not inconsistent with the requirements of this section.

16. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to read as follows:

C.26:2J-4.10 Health maintenance organization, child screening, blood lead, hearing loss; immunizations.

4. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) unless the health maintenance organization offers health care services to any enrollee which include:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Department of Health, which shall consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians. A health maintenance organization shall notify its enrollees, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. The notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and

distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The health care services provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for services provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any services provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 12 of P.L.2005, c.248 (C.26:2J-4.29). This section shall apply to all contracts under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

17. Section 8 of P.L.2019, c.360 (C.26:2J-4.45) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

18. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read as follows:

C.30:4D-6 Medical assistance for qualified applicants.

6. a. Subject to the requirements of Title XIX of the federal Social Security Act, the limitations imposed by this act, and by the rules and regulations promulgated pursuant thereto, the department shall provide medical assistance to qualified applicants, including authorized services within each of the following classifications:

- (1) Inpatient hospital services;
- (2) Outpatient hospital services;
- (3) Other laboratory and X-ray services;
- (4) (a) Skilled nursing or intermediate care facility services;

(b) Early and periodic screening and diagnosis of individuals who are eligible under the program and are under age 21, to ascertain their physical or mental health status and the health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulation of the Secretary of the federal Department of Health and Human Services and approved by the commissioner;

(5) Physician's services furnished in the office, the patient's home, a hospital, a skilled nursing or intermediate care facility, or elsewhere.

As used in this subsection, "laboratory and X-ray services" includes HIV drug resistance testing, including, but not limited to, genotype assays that have been cleared or approved by the federal Food and Drug Administration, laboratory-developed genotype assays, phenotype assays, and other assays using phenotype prediction with genotype comparison, for persons diagnosed with HIV infection or AIDS.

b. Subject to the limitations imposed by federal law, by this act, and by the rules and regulations promulgated pursuant thereto, the medical assistance program may be expanded to include authorized services within each of the following classifications:

(1) Medical care not included in paragraph (5) of subsection a. above, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice, as defined by State law;

- (2) Home health care services;
- (3) Clinic services;
- (4) Dental services;
- (5) Physical therapy and related services;

(6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

- (7) Optometric services;
- (8) Podiatric services;
- (9) Chiropractic services;
- (10) Psychological services;
- (11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age 22 if they are receiving such services immediately before attaining age 21;
- (12) Other diagnostic, screening, preventative, and rehabilitative services, and other remedial care;
- (13) Inpatient hospital services, nursing facility services, and immediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
- (14) Intermediate care facility services;
- (15) Transportation services;
- (16) Services in connection with the inpatient or outpatient treatment or care of substance use disorder, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and substance use disorder treatment center approved by the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et. seq.) and whose staff includes a medical director, and limited those services eligible for federal financial participation under Title XIX of the federal Social Security Act;
- (17) Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of the federal Department of Health and Human Services, and approved by the commissioner;
- (18) Comprehensive maternity care, which may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach, and follow-up services; treatment of conditions which may complicate pregnancy; doula care; and physician or certified nurse midwife delivery services. For the purposes of this paragraph, "doula" means a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth, to help her to achieve the healthiest, most satisfying experience possible;
- (19) Comprehensive pediatric care, which may include: ambulatory, preventive, and primary care health services. The preventive services shall include, at a minimum, the basic number of preventive visits recommended by the American Academy of Pediatrics;
- (20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;
- (21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over;
- (22) Upon referral by a physician, advanced practice nurse, or physician assistant of a person who has been diagnosed with diabetes, gestational diabetes, or pre-diabetes, in accordance with standards adopted by the American Diabetes Association:
 - (a) Expenses for diabetes self-management education or training to ensure that a person with diabetes, gestational diabetes, or pre-diabetes can optimize metabolic control, prevent and

manage complications, and maximize quality of life. Diabetes self-management education shall be provided by an in-State provider who is:

(i) a licensed, registered, or certified health care professional who is certified by the National Certification Board of Diabetes Educators as a Certified Diabetes Educator, or certified by the American Association of Diabetes Educators with a Board Certified-Advanced Diabetes Management credential, including, but not limited to: a physician, an advanced practice or registered nurse, a physician assistant, a pharmacist, a chiropractor, a dietitian registered by a nationally recognized professional association of dietitians, or a nutritionist holding a certified nutritionist specialist (CNS) credential from the Board for Certification of Nutrition Specialists; or

(ii) an entity meeting the National Standards for Diabetes Self-Management Education and Support, as evidenced by a recognition by the American Diabetes Association or accreditation by the American Association of Diabetes Educators;

(b) Expenses for medical nutrition therapy as an effective component of the person's overall treatment plan upon a: diagnosis of diabetes, gestational diabetes, or pre-diabetes; change in the beneficiary's medical condition, treatment, or diagnosis; or determination of a physician, advanced practice nurse, or physician assistant that reeducation or refresher education is necessary. Medical nutrition therapy shall be provided by an in-State provider who is a dietitian registered by a nationally recognized professional association of dietitians, or a nutritionist holding a certified nutritionist specialist (CNS) credential from the Board for Certification of Nutrition Specialists, who is familiar with the components of diabetes medical nutrition therapy;

(c) For a person diagnosed with pre-diabetes, items and services furnished under an in-State diabetes prevention program that meets the standards of the National Diabetes Prevention Program, as established by the federal Centers for Disease Control and Prevention; and

(d) Expenses for any medically appropriate and necessary supplies and equipment recommended or prescribed by a physician, advanced practice nurse, or physician assistant for the management and treatment of diabetes, gestational diabetes, or pre-diabetes, including, but not limited to: equipment and supplies for self-management of blood glucose; insulin pens; insulin pumps and related supplies; and other insulin delivery devices;

(23) Expenses incurred for the provision of group prenatal services to a pregnant woman, provided that:

(a) the provider of such services, which shall include, but not be limited to, a federally qualified health center or a community health center operating in the State:

(i) is a site accredited by the Centering Healthcare Institute, or is a site engaged in an active implementation contract with the Centering Healthcare Institute, that utilizes the Centering Pregnancy model; and

(ii) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

(b) each group prenatal care visit is at least 1.5 hours in duration, with a minimum of two women and a maximum of 20 women in participation; and

(c) no more than 10 group prenatal care visits occur per pregnancy. As used in this paragraph, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the Centering Pregnancy model developed by the Centering Healthcare Institute and which include health assessments, social and clinical support, and educational activities;

(24) Expenses incurred for the provision of pasteurized donated human breast milk, which shall include human milk fortifiers if indicated in a medical order provided by a licensed

medical practitioner, to an infant under the age of six months; provided that the milk is obtained from a human milk bank that meets quality guidelines established by the Department of Health and a licensed medical practitioner has issued a medical order for the infant under at least one of the following circumstances:

(a) the infant is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the infant's mother is medically or physically unable to produce maternal breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; or

(b) the infant meets any of the following conditions:

(i) a body weight below healthy levels, as determined by the licensed medical practitioner issuing the medical order for the infant;

(ii) the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis; or

(iii) the infant has a congenital or acquired condition that may benefit from the use of donor breast milk and human milk fortifiers, as determined by the Department of Health;

(25) Comprehensive tobacco cessation benefits to an individual who is 18 years of age or older, or who is pregnant. Coverage shall include: brief and high-intensity individual counseling, brief and high-intensity group counseling, and telemedicine as defined by section 1 of P.L.2017, c.117 (C.45:1-61); all medications approved for tobacco cessation by the U.S. Food and Drug Administration; and other tobacco cessation counseling recommended by the Treating Tobacco Use and Dependence Clinical Practice Guideline issued by the U.S. Public Health Service. Notwithstanding the provisions of any other law, rule, or regulation to the contrary, and except as otherwise provided in this section:

(a) Information regarding the availability of the tobacco cessation services described in this paragraph shall be provided to all individuals authorized to receive the tobacco cessation services pursuant to this paragraph at the following times: no later than 90 days after the effective date of P.L.2019, c.473: upon the establishment of an individual's eligibility for medical assistance; and upon the redetermination of an individual's eligibility for medical assistance;

(b) The following conditions shall not be imposed on any tobacco cessation services provided pursuant to this paragraph: copayments or any other forms of cost-sharing, including deductibles; counseling requirements for medication; stepped care therapy or similar restrictions requiring the use of one service prior to another; limits on the duration of services; or annual or lifetime limits on the amount, frequency, or cost of services, including, but not limited to, annual or lifetime limits on the number of covered attempts to quit; and

(c) Prior authorization requirements shall not be imposed on any tobacco cessation services provided pursuant to this paragraph except in the following circumstances where prior authorization may be required: for a treatment that exceeds the duration recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use and dependence; or for services associated with more than two attempts to quit within a 12-month period;

(26) Provided that there is federal financial participation available, benefits for expenses incurred in conducting a colorectal cancer screening in accordance with United States Preventive Services Task Force recommendations. The method and frequency of screening to be utilized shall be in accordance with the most recent published recommendations of the United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

No deductible, coinsurance, copayment, or any other cost-sharing requirement shall be imposed for a colonoscopy performed following a positive result on a non-colonoscopy, colorectal cancer screening test recommended by the United States Preventive Services Task Force;

(27) (a) Within 24 months of the effective date of P.L.2023, c.187 (C.30:4D-6u et al.), and conditional on the receipt of all necessary federal approvals and the securing of federal financial participation pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u), community-based palliative care benefits which shall include, but not be limited to, all of the following:

(i) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;

(ii) relief of symptoms, pain, and stress of serious illness;

(iii) improvement of quality of life for both the beneficiary and the beneficiary's family; and

(iv) appropriate care for any age and for any stage of serious illness, along with curative treatment.

(b) Benefits provided under this paragraph shall include, but shall not be limited to, services provided by a hospice pursuant to paragraph (20) of subsection b. of this section, provided that:

(i) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;

(ii) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and

(iii) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided under this paragraph.

(c) Providers authorized to deliver benefits provided under this paragraph shall include Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies licensed to provide hospice care, and other Medicaid-approved licensed health care providers.

(d) Nothing in this paragraph shall be construed to result in the elimination or reduction of covered benefits or services under the Medicaid program.

(e) This paragraph shall not affect a beneficiary's eligibility to receive, concurrently with services provided for in this paragraph, any services, including home health services, for which the beneficiary would have been eligible in the absence of this paragraph, to the extent that services are not duplicative; and

(28) (a) medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including, but not limited to:

(i) hormonal therapies such as hormone replacement therapy and bioidentical hormone treatments;

(ii) non-hormonal treatments, including medications to manage menopausal symptoms;

(iii) behavioral health care services;

(iv) pelvic floor physical therapy;

(v) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(vi) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(vii) counseling and education regarding menopause management.

(b) Individuals receiving medical assistance shall be provided with clear and accessible information regarding covered perimenopause and menopause related treatments.

(c) As used in this paragraph:

“Menopause” means the permanent end of a female’s menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

“Perimenopause” means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

c. Payments for the foregoing services, goods, and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto, and, where applicable, subject to the agreement of insurance provided for under this act. The payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, the recipient's family, the recipient's representative, or others on the recipient's behalf for the services, goods, and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods, or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative, or others on his behalf for such services, goods, and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods, or supplies not authorized by this act, if the recipient elected to receive the services, goods, or supplies with the knowledge that they were not authorized.

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any person qualified to perform the service or services required (including an organization which provides such services or arranges for their availability on a prepayment basis), who undertakes to provide the individual such services.

No copayment or other form of cost-sharing shall be imposed on any individual eligible for medical assistance, except as mandated by federal law as a condition of federal financial participation.

e. Anything in this act to the contrary notwithstanding, no payments for medical assistance shall be made under this act with respect to care or services for any individual who:

(1) Is an inmate of a public institution (except as a patient in a medical institution); provided, however, that an individual who is otherwise eligible may continue to receive services for the month in which he becomes an inmate, should the commissioner determine to expand the scope of Medicaid eligibility to include such an individual, subject to the limitations imposed by federal law and regulations, or

(2) Has not attained 65 years of age and who is a patient in an institution for mental diseases, or

(3) Is over 21 years of age and who is receiving inpatient psychiatric hospital services in a psychiatric facility; provided, however, that an individual who was receiving such services immediately prior to attaining age 21 may continue to receive such services until the individual reaches age 22. Nothing in this subsection shall prohibit the commissioner from extending medical assistance to all eligible persons receiving inpatient psychiatric services; provided that there is federal financial participation available.

f. (1) A third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in this or another state when determining the person's eligibility for enrollment or the provision of benefits by that third party.

(2) In addition, any provision in a contract of insurance, health benefits plan, or other health care coverage document, will, trust, agreement, court order, or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential eligibility for or receipt of Medicaid

benefits shall be null and void, and no payments shall be made under this act as a result of any such provision.

(3) Notwithstanding any provision of law to the contrary, the provisions of paragraph (2) of this subsection shall not apply to a trust agreement that is established pursuant to 42 U.S.C. s.1396p(d)(4)(A) or (C) to supplement and augment assistance provided by government entities to a person who is disabled as defined in section 1614(a)(3) of the federal Social Security Act (42 31 U.S.C. s.1382c (a)(3)).

g. The following services shall be provided to eligible medically needy individuals as follows:

(1) Pregnant women shall be provided prenatal care and delivery services and postpartum care, including the services cited in paragraphs (1), (3), and (5) of subsection a. of this section and paragraphs (1) through (10), (12), (15), and (17) of subsection b. of this section, and nursing facility services cited in paragraph (13) of subsection b. of this section.

(2) Dependent children shall be provided with services cited in paragraphs (3) and (5) of subsection a. of this section and paragraphs (1), (2), (3), (4), (5), (6), (7), (10), (12), (15), and (17) of subsection b. of this section, and nursing facility services cited in paragraph (13) of subsection b. of this section.

(3) Individuals who are 65 years of age or older shall be provided with services cited in paragraphs (3) and (5) of subsection a. of this section and paragraphs (1) through (5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of subsection b. of this section, and nursing facility services cited in paragraph (13) of subsection b. of this section.

(4) Individuals who are blind or disabled shall be provided with services cited in paragraphs (3) and (5) of subsection a. of this section and paragraphs (1) through (5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of subsection b. of this section, and nursing facility services cited in paragraph (13) of subsection b. of this section.

(5) (a) Inpatient hospital services, paragraph (1) of subsection a. of this section, shall only be provided to eligible medically needy individuals, other than pregnant women, if the federal Department of Health and Human Services discontinues the State's waiver to establish inpatient hospital reimbursement rates for the Medicare and Medicaid programs under the authority of section 601(c)(3) of the Social Security Act Amendments of 1983, Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be extended to other eligible medically needy individuals if the federal Department of Health and Human Services directs that these services be included.

(b) Outpatient hospital services, paragraph (2) of subsection a. of this section, shall only be provided to eligible medically needy individuals if the federal Department of Health and Human Services discontinues the State's waiver to establish outpatient hospital reimbursement rates for the Medicare and Medicaid programs under the authority of section 601(c)(3) of the Social Security Act Amendments of 1983, Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be extended to all or to certain medically needy individuals if the federal Department of Health and Human Services directs that these services be included. However, the use of outpatient hospital services shall be limited to clinic services and to emergency room services for injuries and significant acute medical conditions.

(c) The division shall monitor the use of inpatient and outpatient hospital services by medically needy persons.

h. In the case of a qualified disabled and working individual pursuant to section h6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the only medical assistance provided under this act shall be the payment of premiums for Medicare part A under 42 U.S.C. ss.1395i-2 and 1395r.

i. In the case of a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)(10)(E)iii, the only medical assistance provided under this act shall be the payment of

premiums for Medicare part B under 42 U.S.C. s.1395r as provided for in 42 U.S.C. s.1396d(p)(3)(A)(ii).

j. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(aa), the only medical assistance provided under this act shall be payment for authorized services provided during the period in which the individual requires treatment for breast or cervical cancer, in accordance with criteria established by the commissioner.

k. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(ii), the only medical assistance provided under this act shall be payment for family planning services and supplies as described at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting.

l. As used in paragraph (12) of subsection b. of this section, preventative care includes, but is not limited to, immunizations that have in effect a recommendation from the Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians.

19. Section 9 of P.L.2019, c.360 (C.52:14-17.29dd) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

20. Section 10 of P.L.2019, c.360 (C.52:14-17.46.6o) is amended to read as follows:

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 Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians;

(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.

21. The head of each State agency shall adopt such rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as the head of the State agency may deem necessary, in order to replace any references to the immunization or vaccination recommendations or guidance of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention in rule or regulation with references to the recommendations of, and guidance issued by, the Department of Health, which shall in making its recommendations consider the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in the federal Department of Health and Human Services and, as appropriate, the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians.

22. This act shall take effect immediately and shall apply to policies or contracts issued or renewed on or after the effective date.

Approved January 18, 2026.