§4320-A. Coverage of preventive and primary health services

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive and primary health services as required by this section. [PL 2019, c. 653, Pt. C, §1 (AMD).]

1. Preventive services. A health plan must, at a minimum, provide coverage for:

A. The evidence-based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force or equivalent rating from a successor organization; [PL 2017, c. 343, §1 (NEW).]

B. With respect to the individual insured, immunizations that have a recommendation from the federal Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices and that are consistent with the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians or the American College of Obstetricians and Gynecologists or a successor organization; [PL 2017, c. 343, §1 (NEW).]

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration that are consistent with the recommendations of the American Academy of Pediatrics or a successor organization; and [PL 2017, c. 343, §1 (NEW).]

D. With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration women's preventive services guidelines that are consistent with the recommendations of the American College of Obstetricians and Gynecologists women's preventive services initiative. [PL 2017, c. 343, §1 (NEW).]

[PL 2017, c. 343, §1 (NEW).]

2. Change in recommendations. If a recommendation described in subsection 1 is changed during a health plan year, a carrier is not required to make changes to that health plan during the plan year.

[PL 2017, c. 343, §1 (NEW).]

3. Primary health services. An individual or small group health plan with an effective date from January 1, 2021 to December 31, 2022 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copayments for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent shall conduct a study analyzing the effects of this subsection on premiums based on experience in plan years 2020 and 2021. The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2021, c. 638, §1 (AMD).]

3-A. Parity in cost sharing for primary care and behavioral health office visits; individual or small group health plan. An individual or small group health plan with an effective date on or after

January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copayments for primary care office visits and behavioral health office visits in a plan year count toward the deductible. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 638, §2 (NEW).]

3-B. Parity in cost sharing for primary care and behavioral health office visits; group health plan. A group health plan, other than a small group health plan subject to subsection 3-A, with an effective date on or after January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 638, §3 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW). PL 2017, c. 343, §1 (AMD). PL 2019, c. 653, Pt. C, §1 (AMD). PL 2021, c. 638, §§1-3 (AMD).