Uniform Act on Insurance Coverage of All Immunizations

SECTION 1. DEFINTIONS

For the purposes of this act:

(a) "beneficiary" means a person or persons specified by a policyholder as eligible to receive benefits under the insurance contract or policy.

(b) "co-insurance" means the percentage of a provider's negotiated fee the enrollee must pay for care, up to a yearly defined maximum.

(c) "co-payment" means a cost-sharing arrangement in which a beneficiary pays a specified charge for a specified service. The beneficiary is usually responsible for payment at the time the service is rendered.

(d) "cost-sharing" means a method of reimbursement for health care services that holds the patient responsible for a portion or percentage of the charge with an attending strategy to serve as a means of reducing utilization.

(e) "covered benefit" means a written health care benefit document that outlines the benefit package to be provided to either individual beneficiaries or a purchasing group or employer, with a corresponding sum for each service specified for beneficiaries by an insurer in the state.

(f) "deductible" means a specific dollar amount you must pay before the benefit plan begins paying for covered services.

(g) "dependent" means an enrolled health plan member who has coverage tied to that of the sponsor; may be a spouse or an unmarried child, or a stepchild or legally adopted child of either the beneficiary or the beneficiary's spouse, whose primary domicile is with the beneficiary, except for the other arrangements as approved by the plan; often dependent children status is also delineated by those under the age of 18, or children attending college full-time under a specified age.

(h) "health benefits plan" means a group or individual insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group or individual arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(i) “network” means a health benefit plan that operates through a series of contracts with multiple physician groups and hospitals to provide a defined group of providers from which a health plan member may choose from to receive covered health services. Services obtained from providers included in the defined group charge the health plan member an agreed upon discounted fee.

(j) **“**State” means a State of the United States, the District of Columbia, Puerto Rico, the US Virgin Islands, or any territory or insular possession subject to the jurisdiction of the US.

SECTION 2. SUBSTANCE OF THE ACT

(a) Covered Immunization Services

(1) To the extent permitted by federal law, any health benefit plan issued, renewed, extended, or modified for delivery in this state, must include at a minimum, immunizations as a covered benefit for all beneficiaries and their dependents, regardless of age according to the most recent schedules recommended by the Advisory Committee on Immunization Practices (ACIP), of the U.S. Department of Health and Human Services.

(b) Cost Sharing Provisions

(1) (A) Health Benefit Plans will pay 100% of the charges for the ACIP-Recommended immunizations. For purposes of this paragraph, charges include the cost of the biological product and any costs associated with the administration of such product.

(1) (B) Health Benefit Plans subject to this act must explicitly provide these services, the services shall not be subject to any co-payment, coinsurance, deductible, or dollar limit provisions in the health benefit plan.

(c) Network Provisions

(1) Health benefit plans will cover all immunizations regardless of whether the immunization is obtained in or out of the plan's network.

SECTION 3. UNIFORMITY OF APPLICATION AND CONSTRUCTION

(a) In applying and construing this Uniform Act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among States that enact it.

SECTION 4. SHORT TITLE. This [Act] may be cited as the Uniform Immunization Act.

SECTION 5. SEVERABILITY CLAUSE. The provisions of this Act are severable. If any provision of this Act or its application is held invalid, that invalidity shall not affect other provisions or applications of this Act which can be given effect without regard to the provision or application that has been held to be invalid.

SECTION 6. EFFECTIVE DATE.

The provisions of this Act shall apply to any health benefit plan issued, renewed, extended, or modified for delivery in this state on or after:

Options: (1) Date of enactment.

(2) A date (x) days after the date of enactment.

(3) (X) days after (insert description of regulations or other guidance) is issued by (insert name of administering agency)

SECTION 7. APPLICATION TO EXISTING RELATIONSHIPS

Drafter may want to include special rules that describe how the provisions of this Act apply to any health benefit plan issued, renewed, extended, or modified for delivery in this state before the effective date described in Section 6.