A STUDY OF NEW JERSEY ASSEMBLY BILL 3523

REQUIRES HEALTH INSURERS TO COVER COLORECTAL CANCER SCREENINGS AND ELIMINATES COST-SHARING REQUIREMENTS FOR CERTAIN COLONOSCOPIES

Report to the New Jersey Assembly

October 11, 2022

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A-3523 (see Appendix I), a bill requiring coverage of colorectal cancer screenings recommended by United States Preventive Services Task Force (USPSTF) and eliminating cost-sharing requirements for certain colonoscopies. Specifically, A-3523 supplements various parts of statutory law in two ways: (1) by removing from state law the references to mandating coverage for colorectal cancer screening at age 50 and for services provided to persons otherwise prescribed by law, and instead tying coverage requirements to the USPSTF recommendations; and (2) by providing that "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."[i] The bill was referred to the MHBAC by Assembly Financial Institutions and Insurance Committee Chairman John F. McKeon.

The bill applies to hospital, medical and health service corporations, commercial group insurers and health maintenance organizations. The bill also applies to health benefits plans issued pursuant to the Individual Health Coverage Program, the Small Employer Health Benefits Program, the State Health Benefits Program, the School Employees' Health Benefits Program, and to the State's Medicaid Program. The bill does not apply to Medicare Supplement, Medicare Advantage, Medicare, self-funded plans, multiple employer welfare arrangements, and other coverage not regulated by the New Jersey Department of Banking and Insurance (DOBI). The MHBAC estimates that the mandate would impact approximately 2,088,708 people, or roughly 22.5% of New Jersey residents, i.e., those covered under New Jersey-regulated plans.

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The Act does not ask the Commission to recommend whether or not to enact the legislation, and the Commission does not do so here. The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections. The MHBAC has sought to include information from a number of reputable sources that it found credible, but recognizes that opinions and analyses may differ.

LEGISLATIVE HISTORY

Prior Legislative Session

While A-3523 is new legislation for the 2022-23 Legislative Session, the Legislature has considered similar legislation in the past. A-5034 from last session, like A3524, would have lowered the age at which a health benefits plan would be required to cover colorectal cancer screening from 50 to 45. Unlike A-3524, however, last session's bill did not address cost-sharing requirements for colonoscopies performed following a positive result on a non-colonoscopy, colorectal cancer screening test. A-5034 was introduced on January 19, 2020, was referred to the Assembly Health Committee and was reported out with Committee amendments on June 2, 2021. The amendments were to clarify that the requirements also applied to health benefits plans offered by the School Employees' Health Benefits Plan as well as some other technical amendments. The bill was referred to Assembly Appropriations but did not proceed any further.

A fiscal estimate for A-5034 was issued on July 2, 2021. The Office of Legislative Services noted the following in the fiscal note:

- "The Office of Legislative Services (OLS) notes that in accordance with the New Jersey Colorectal Cancer Screening law, Horizon's published medical policy guiding coverage for the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) provides 100 percent coverage for colorectal cancer screening for persons who are 50 years of age and older and for persons of any age with a letter of medical necessity from their doctor.
- The bill will increase costs to the SHBP and the SEHBP by the number of plan participants between 45 and 49 years of age who will be newly eligible for regular colorectal cancer screenings commencing at 45 years of age."

OLS noted that they lacked specific data on enrollment and the cost of the procedures, so it was not possible to calculate a cost estimate for the bill.

The Senate version of the bill from last session, S-3282, was introduced on December 14, 2020 and referred to Senate Commerce. On February 11, 2021, the bill was reported out of committee with committee amendments and then was referred to Senate Budget and Appropriations. The bill did not move further.

Current Legislative Session

A-3523 was introduced on March 8, 2022 and referred to the Assembly Financial Institutions and Insurance Committee. In the Senate, S-2305, which is identical to A-3523, was introduced on

March 21, 2022 and was referred to the Senate Commerce Committee. The Senate bill was considered and reported favorably from the Senate Commerce Committee on June 9, 2022.[ii] The bill was then referred to the Senate Budget and Appropriations Committee.

As of the writing of this report, the bill has not been heard in the Assembly Financial Institutions and Insurance Committee nor the Senate Budget and Appropriations Committee, and it has not been amended in either house from its original introduced text.

OTHER FEDERAL AND STATE LAWS AND RELATED GUIDANCE DOCUMENTS MANDATING COVERAGE FOR CERTAIN SCREENING

The Patient Protection and Affordable Care Act (ACA), Section 2713, amending the Public Health Services Act, and implementing regulations, requires group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to provide coverage of certain preventive services without cost-sharing. For purposes of screening, the ACA requires coverage of evidence-based items or services that have an "A" or "B" recommendation rating from the USPSTF. A final recommendation statement from the USPSTF on colorectal cancer screening was updated on May 18, 2021. It found the following:

Population	Recommendation	Grade
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

This current recommendation updated the previous 2016 updates in one way: the USPSTF now recommends offering screening starting at age 45 years (B recommendation), which had been

rated as a "C" grade previously. As a result, because of the ACA coverage requirements, this USPSTF change automatically applied to New Jersey health benefits plans.

New Jersey also enacted its own, state-based version of this ACA coverage requirement with the passage of P.L. 2019, c.360. That state law tracks the ACA's mandated coverage requirements, including mandate coverage, without cost sharing, for "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."

While the state law may seem redundant, its impact on state-regulated plans could be significant if the ACA were ever repealed or invalidated. In fact, this is not an academic matter, as there is currently a lawsuit, *Kelley v. Becerra*, N.D. Tex., No. 20-cv-00283, that alleges that the ACA's preventive services requirement is unconstitutional on multiple grounds. In a decision dated September 7, 2022, the judge ruled that the Affordable Care Act's process for determining what kinds of preventive care must be fully covered by private health insurance is unconstitutional, as it violates the appointment clause of the U.S. Constitution and the Court reserved ruling on the appropriate remedy. As of the publication of this report, this matter is not fully resolved. The court ordered further briefing and it is possible that this matter may be appealed. Should the plaintiffs prevail and the ACA's preventive services mandate be invalidated, the state law may provide a different basis for a coverage mandate for certain preventive services for state-regulated plans.

Also, on January 10, 2022, the U. S. Department of Labor issued FAQs, which among other things, provided clarifying guidance on coverage of preventive services and specifically coverage of colonoscopies pursuant to USPSTF recommendations. The FAQs provide: "A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete. The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing in accordance with the requirements of PHS Act section 2713 and its implementing regulations."[iii] The FAQs make clear that this requirement is effective for plan or policy years beginning on May 31, 2022.

STAKEHOLDER POSITIONS

The MHBAC enabling statute requires an analysis of "the demand for the proposed mandated health benefit from the public and the source and extent of opposition to mandating the health benefit." Stakeholders' positions of support or opposition for the cost-sharing cap bills A-3523 and S-2305, as expressed through testimony and witness slips, are presented in Table 1.

Table 1. Stakeholders' Positions on A-3523 and S-2305

Organization	**Position (In Favor/Opposed/Seeks Amendment)**	**Comment**
New Jersey Association of Health Plans	In Favor	
Fight Colorectal Cancer	In Favor	
American Cancer Society	In Favor	
American Cancer Society Cancer Action Network	In Favor	
New Jersey Association of Osteopathic Physicians and Surgeons	In Favor	
Medical Society of New Jersey	In Favor	
New Jersey Society of Pathologists	In Favor	
New Jersey Section of the American College of Obstetricians and Gynecologists	In Favor	
New Jersey Pharmacists Association and Garden State Pharmacy Owners	In Favor	
Independent Pharmacy Alliance and Omega Pharmacy Group	In Favor	
New Jersey Society of Interventional Pain Physicians	In Favor	

Allied Digestive Health	In Favor	

Source: Testimony and witness slips submitted to the Senate Commerce Committee at its meeting on S-2305, June 9, 2022.

SOCIAL IMPACT AND MEDICAL EVIDENCE – COLORECTAL CANCER

Colorectal Cancer in the United States

Colorectal cancer (CRC) is the third most frequent cause of death from cancer for both men and women in the United States; when the causes are combined for both sexes, CRC is the second most common cause of cancer death.[iv] For 2020, it was estimated that roughly 147,950 people would be diagnosed with CRC and 53,200 would die from the disease. Of these, it was estimated that 17,930 diagnosed cases and 3,640 deaths would be in individuals aged younger than 50 years.[v]

Between 2011 and 2016, CRC incidence fell by 3.3% annually for individuals aged 65 years or older, but rose 1% annually for individuals aged 50 to 64 years and 2.2% annually among people aged younger than 50 years.[vi] Death rates from CRC for the years 2008 to 2017 fell by 3% per year for individuals aged 65 years and older, fell by 0.6% annually for people aged 50 to 64 years, but rose 1.3% per year in individuals aged younger than 50 years.[vii] A study of current CRC statistics found that, "[M]ore than one-half of all cases and deaths are attributable to modifiable risk factors, such as smoking, an unhealthy diet, high alcohol consumption, physical inactivity, and excess body weight….CRC morbidity and mortality can also be mitigated through appropriate screening and surveillance."[viii]

CRC incidence and mortality rates vary by sex and racial/ethnic groups. CRC incidence, for example, is similar for women and men younger than 45 years of age, but incidence rates for men are 40% to 50% higher than for women aged 55 to 74 years. For the period 2012 to 2016, incidence rates in non-Hispanic blacks (45.7 per 100,000 population) were 20% higher than incidence rates for non-Hispanic whites (38.6 per 100,000 population) and 50% higher than rates for Asian Americans/Pacific Islanders (30.0 per 100,000 population). As for mortality in the period 2013 to 2017, CRC death rates for blacks (19.0 per 100,000) were almost 40% higher than those for whites (13.8 per 100,000) and double the death rates for Asian Americans/Pacific Islanders (9.5 per 100,000).[ix]

Colorectal Cancer in New Jersey

CRC incidence and mortality rates for New Jersey and the United States are presented in Table 2. The data from two recent time periods are broken out by sex and race/ethnicity groups. For

New Jersey and the United States, CRC incidence rates were highest for non-Hispanic blacks and lowest for Hispanics for both men and women in both time periods. The CRC incidence rates for non-Hispanic whites fell between the other groups. CRC incidence rates declined for all the groups in New Jersey and the United States from the earlier to the more recent time period.

CRC mortality rates are presented for the same groups over the same time frames. As with the incidence rates, mortality rates are highest for non-Hispanic blacks and lowest for Hispanics for both men and women in both time periods, with mortality rates for whites falling between the rates for the other groups. CRC mortality rates fell for all New Jersey and US groups from the earlier to the more recent time period, except for Hispanic men in New Jersey. These data are presented in Table 2.

Table 2. Colorectal Cancer Incidence and Mortality Rates in Two Time Periods, by Sex and Race/Ethnicity: New Jersey and United States

	Colorectal Cancer Incidence Rates (2009-2013)/(2012-2016)					
	Men			Women		
	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
New Jersey	49.9/48.1	57.7/54.1	45.1/43.8	39.2/36.9	43.1/41.5	35.5/32.9
United States	46.1/44.0	58.3/53.8	42.8/40.8	35.2/33.9	42.7/39.9	29.8/28.7

	Colorectal Cancer Mortality Rates (2010-2014)/(2013-2017)					
	Men			Women		
	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
New Jersey	18.4/17.1	28.0/24.2	11.9/12.4	13.2/12.4	15.8/14.5	8.7/8.1
United States	17.3/16.3	25.9/23.8	15/14.1	12.3/11.7	16.9/15.6	9.2/8.7

Rates are per 100,000 and age adjusted to the 2000 US standard population.
Source: American Cancer Society, "Colorectal Cancer Facts & Figures 2017-2019" and American Cancer Society, "Colorectal Cancer Facts & Figures 2020-2022."
(https://www.cancer.org/research/cancer-facts-statistics/colorectal-cancer-facts-figures.html)

Medical Evidence

The typical progression from a precancerous polyp to advance-stage colorectal cancer takes years. As a result, early screening can lead to detection and removal of precancerous polyps, lowering the incidence of CRC, and the detection of disease at an earlier stage, when treatment is more likely to be effective, reducing CRC mortality.[x] In 2018 the American Cancer Society (ACS) issued CRC guidelines recommending that all adults aged 45 years and older be screened regularly with a high-sensitivity stool-based test or a visual examination. The age guidelines were lowered from 50 years to 45 years because studies found that CRC incidence rates were rising in younger age groups and because, "[M]odeling studies demonstrated that the balance of benefit to harm was more favorable for beginning screening at age 45 than at 50."[xi]

In 2021 the USPSTF published its recommendation that adults aged 45 to 49 years be screened for colorectal cancer. The recommendation came with a "B" grade, meaning the USPSTF recommends the service and found there is a "high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial."[xii] As with the revised ACS screening guidelines, the USPSTF also cited recent research findings that CRC risk is rising in younger cohorts and that beginning screening at age 45 could moderately increase life-years gained and reduce CRC incidence and mortality compared to starting screening at age 50.

CRC screening procedures fall into two categories – stool tests and visual examinations. Stool tests detect blood in in stools that comes from intermittent bleeding from cancerous tumors and some large adenomas. A positive finding from a stool test should be followed up in a timely manner with a colonoscopy. The three types of recommended stool tests are: 1) guaiac-based fecal occult blood test (gFOBT), which uses a chemical reaction to detect blood in the stool and should be repeated annually; 2) fecal immunochemical test (FIT), which uses antibodies against hemoglobin to detect human blood in the stool and is about twice as likely to detect advanced adenomas and cancer as gFOBT. CRC screening using FIT should also be repeated annually; and 3) multitargeted stool DNA test, which detects blood in the stool, but also detects multiple genetic mutations in the DNA of cells that are shed into the stool by large adenomas and CRC. The multitargeted stool DNA test should be administered every three years.[xiii]

There are also three recommended visual screening procedures. Colonoscopy is the most common CRC screening test and permits a gastroenterologist to examine visually the entire colon and rectum. Colonoscopy can be used as a screening test on its own or be used to follow up an abnormal finding from another screening test. A colonoscopy should be repeated every ten years for patients with average CRC risk and negative test results. Flexible sigmoidoscopy is an older procedure that permits a clinician to visualize the rectum and distal one-third of the colon; if the clinician identifies a polyp or tumor, follow up requires a colonoscopy. The third visual

screening test is a computed tomographic colonography (CTC), or virtual colonoscopy. This imaging procedure generates a 2- or 3-dimensional view of the entire colon and rectum using a CT scanner.[xiv] CTC screening should be repeated every 5 years.

Some of the CRC screening tests come with modest potential risks, while others do not. There are no harmful risks from any of the stool-based screening tests, although they can yield false-positive or false-negative results. The risks from follow up colonoscopies to any positive screening result amounts to 17.5 serious bleeding events and 5.4 bowel perforations per 10,000 colonoscopies.[xv] The risk rates for screening colonoscopies (*i.e.*, those not performed after a positive result from another screening test) are lower, with 14.6 major bleeding events and 3.1 perforations per 10,000 colonoscopies. These risks increased with the increasing age of the patient.[xvi] A full comparison of the benefits and limits of the stool and visual examination tests is presented in Table 3.

Table 3. Benefits and Limits of Colorectal Cancer Screening Tests

Test	Benefits	Limits
Fecal immunochemical test (FIT)	No direct risk to the colon No bowel prep No pre-test diet or medication changes needed Sampling done at home Fairly inexpensive	Can miss many polyps and some cancers Can have false-positive test results Needs to be done every year Colonoscopy will be needed if abnormal
Guaiac-based fecal occult blood test (gFOBT)	No direct risk to the colon No bowel prep	Can miss many polyps and some cancers Can have false-positive test results

	Sampling done at home Inexpensive	Pre-test diet changes (and possibly medication changes) are needed Needs to be done every year Colonoscopy will be needed if abnormal
Stool DNA test	No direct risk to the colon No bowel prep No pre-test diet or medication changes needed Sampling done at home	Can miss many polyps and some cancers Can have false-positive test results Should be done every 3 years Colonoscopy will be needed if abnormal Still fairly new – may have insurance coverage issues
Colonoscopy	Can usually look at the entire colon Can biopsy and remove polyps Done every 10 years Can help find some other diseases	Can miss small polyps Full bowel prep needed Costs more on a one-time basis than other forms of testing Sedation is usually needed, in which case you will need someone to drive you home You may miss a day of work

		Small risk of bleeding, bowel tears, or infection
CT colonography (virtual colonoscopy)	Fairly quick and safe Can usually see the entire colon Done every 5 years No sedation needed	Can miss small polyps Full bowel prep needed Some false-positive test results Exposure to a small amount of radiation Can't remove polyps during testing Colonoscopy will be needed if abnormal Still fairly new – may have insurance coverage issues
Flexible sigmoidoscopy	Fairly quick and safe Usually doesn't require full bowel prep Sedation usually not used Does not require a specialist Done every 5 years	Not widely used as a screening test Looks at only about a third of the colon Can miss small polyps Can't remove all polyps May be some discomfort Very small risk of bleeding, infection, or bowel tear

		Colonoscopy will be needed if abnormal

Source: American Cancer Society, "Colorectal Cancer Screening Tests." Accessed 8/10/22. (https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/screening-tests-used.html)

Colorectal Cancer Screening Prevalence: US vs. New Jersey

CRC screening prevalence in the US using any recommended test ("up-to-date screening") for individuals aged 50 years or above has risen from 38% in 2000 to 66% in 2018.[xvii] Within that broad age cohort, there were significant differences in 2018, however, with a screening prevalence of 48% for ages 50 to 54 years, 68% for those aged 55 to 64 years, and 71% for those aged 65 years and older. Men and women aged 50 to 75 years had roughly the same up-to-date CRC screening prevalence, with men at 67% and women at 66%, according to the 2018 data. If CRC screening is broken down by race, non-Hispanic whites aged 50 to 75 years had a screening prevalence of 69%, non-Hispanic blacks aged 50 to 75 years had a screening prevalence of 66%, and Hispanics aged 50 to 75 years had a screening prevalence of 59% in 2018.

For New Jersey, in 2018, CRC screening prevalence for individuals aged 50 years and above was 68%, with variations by age group similar to the national data. For New Jerseyans aged 50 to 64 years, for example, the screening prevalence was 59%, while the screening prevalence for New Jerseyans aged 65 years and above was 75%. For non-Hispanic white New Jerseyans aged 50 years and above, the screening prevalence was 69%, while the CRC screening prevalence for non-Hispanic blacks aged 50 and older was 76%.[xix]

Screening Indications in Population Subgroups

There are special CRC screening guidelines for several population subgroups. Individuals with a family history of CRC, for instance, are advised to begin screening at an earlier age and to screen more frequently. A recent research article found that this elevated risk of CRC declines with age and that, "[I]t is cost effective to gradually increase the screening interval if several subsequent screening colonoscopies have negative results and no new cases of CRC are found in family members."[xx] A 2022 analysis looked at the cost-effectiveness of various screening strategies for overweight and obese men and women, who are at greater risk of CRC. The authors concluded

that it was cost-effective to begin CRC screening for all overweight and obese men and women at age 40 using a fecal immunochemical test (FIT) or for all of these patients using colonoscopy at age 45. The authors also found it was cost-effective to begin CRC screening in the most obese weight groups of men using colonoscopy at age 40.[xxi]

FINANCIAL IMPACT

Federal and state requirements are already in place mandating coverage with no cost sharing for colorectal cancer screening consistent with the USPSTF recommendations (including those 45-49 years of age) and for a colonoscopy performed following a positive result on a non-colonoscopy, colorectal cancer screening test recommended by the USPSTF. As a result, the bill has no impact on coverage requirements that the MHBAC could discern and there is no financial impact of the legislation.

CONCLUSION

Balancing Social Impact, Medical Evidence, and Financial Impact

The benefits of colorectal cancer screening for certain age cohorts and those at high risk have been well documented as discussed above and as has been documented in the USPSTF Final Recommendation on colorectal cancer screening. Because insurers in New Jersey are required to provide coverage consistent with USPSTF guidelines, the bill will not have a unique social, medical or financial impact in New Jersey. Nevertheless, A-3523 serves a useful function in updating and aligning New Jersey statutes with federal law, other state law, and with best practices.

ENDNOTES

[i] The MHBAC notes that the bill's language might be interpreted to mean that every future colonoscopy for a patient with a positive result from a non-colonoscopy colorectal screening test must be covered without cost-sharing. This possible interpretation could be eliminated with the inclusion of language such as, "No cost-sharing requirement shall be imposed for a colonoscopy performed as a result of an abnormal result on a USPSTF indicated non-colonoscopy screening test to identify or exclude definitively the diagnosis of colorectal cancer."

[ii] https://pub.njleg.state.nj.us/Bills/2022/S2500/2305_S1.PDF

[iii] Carriers have noted that payers of all types are sometimes faced with a practical problem of determining whether or not a colonoscopy is being performed as a result of an abnormal non-colonoscopy screening test. Applicable law prohibits cost-sharing for the former, but not for the latter, and in some cases (e.g., qualified high deductible health plans) cost-sharing is required. Current federal and state laws do not require a colonoscopist to report that a colonoscopy is being performed as part of the USPSTF recommended screening guidelines.

[iv] Siegel, RL, Miller, KD, *et al.*, "Colorectal Cancer Statistics, 2020." CA: A Cancer Journal for Clinicians, March 5, 2020. Accessed 8/10/22. (https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21601)

[v] *Ibid.*

[vi] Simon, Stacy, "Colorectal Cancer Rates Rise in Younger Adults." American Cancer Society, March 5, 2020. Accessed 8/10/22. (https://www.cancer.org/latest-news/colorectal-cancer-rates-rise-in-younger-adults.html)

[vii] Siegel *et al.*, *op cit.*

[viii] *Ibid.*

[ix] *Ibid.*

[x] American Cancer Society, "Colorectal Cancer Facts & Figures 2020-2022." (https://www.cancer.org/research/cancer-facts-statistics/colorectal-cancer-facts-figures.html)

[xi] *Ibid.*

[xii] United States Preventive Services Task Force, "Final Recommendation Statement, Colorectal Cancer: Screening," May 18, 2021. Accessed 8/23/22. (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening)

[xiii] American Cancer Society, *op. cit.*

[xiv] *Ibid.*

[xv] United States Preventive Services Task Force, *op cit.*

[xvi] *Ibid.*

[xvii] Siegel *et al., op cit.*

[xviii] American Cancer Society, *op. cit.*

[xix] *Ibid.*

[xx] Naber, SK, Kuntz, KM, *et al.*, "Cost Effectiveness of Age-Specific Screening Intervals for People with Family Histories of Colorectal Cancer." Gastroenterology, January 2018, 154(1):105-116. Accessed 8/10/22. (https://pubmed.ncbi.nlm.nih.gov/28964749/)

[xxi] Yeoh, Aaron, Mannalithara, Ajitha, and Ladabaum, Uri, "Cost-Effectiveness of Earlier or More Intensive Colorectal Cancer Screening in Overweight and Obese Patients." Clinical Gastroenterology and Hepatology, August 4, 2022. Accessed 8/17/22. (https://www.sciencedirect.com/science/article/abs/pii/S1542356522007261)

ASSEMBLY, No. 3523

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED MARCH 8, 2022

Sponsored by:
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SYNOPSIS

Requires health insurers to cover colorectal cancer screenings recommended by United States Preventive Services Task Force and eliminates cost-sharing requirements for certain colonoscopies.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 9/15/2022)

AN ACT concerning health benefits for colorectal cancer screenings, and amending and supplementing various parts of the statutory law.

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

1. Section 1 of P.L.2001, c.295 (C.17:48-6y) is amended to read as follows:

1. a. Every hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), 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 benefits to any named subscriber or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening **[**at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available**]** 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**]** recently published **[**guidelines**]** recommendations of the **[**American Cancer Society**]** United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.**]**

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the contract.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

d. The provisions of this section shall apply to all hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.
(cf: P.L.2001, c.295, s.1)

2. Section 2 of P.L.2001, c.295 (C.17:48A-7x) is amended to read as follows:

2. a. Every medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), 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 benefits to any named subscriber or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening **[**at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available**]** 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**]** recently published **[**guidelines**]** recommendations of the **[**American Cancer Society**]** United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.**]**

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the contract.

d. The provisions of this section shall apply to all medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.
(cf: P.L.2001, c.295, s.2)

3. Section 3 of P.L.2001, c.295 (C.17:48E-35.23) is amended to read as follows:

3. a. Every health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), 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 benefits to any named subscriber or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening **[**at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available**]** 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**]** recently published **[**guidelines**]** recommendations of the **[**American Cancer Society**]** United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.**]**

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the contract.

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

(cf: P.L.2001, c.295, s.3)

4. Section 4 of P.L.2001, c.295 (C.17B:26-2.1u) is amended to read as follows:

4. a. Every individual policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in

this State pursuant to N.J.S.[17B: 23-1 et seq.] 17B:26-1 et seq., 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 benefits to any named insured or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening [at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available] 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] recently published [guidelines] recommendations of the [American Cancer Society] United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.]

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the policy.

d. The provisions of this section shall apply to all health insurance policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2001, c.295, s.4)

5. Section 5 of P.L.2001, c.295 (C.17B:27-46.1y) is amended to read as follows:

5. a. Every group policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S.17B:27-26 et seq., 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 benefits to any named insured or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening

[at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available] 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] recently published [guidelines] recommendations of the [American Cancer Society] United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.]

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the policy.

d. The provisions of this section shall apply to all health insurance policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2001, c.295, s.5)

6. Section 6 of P.L.2001, c.295 (C.17B:27A-7.7) is amended to read as follows:

6. a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide benefits to any person covered thereunder for expenses incurred in conducting a colorectal cancer screening [at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the

most reliable, medically recognized screening test available] 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] recently published [guidelines] recommendations of the [American Cancer Society] United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.]

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

d. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2001, c.295, s.6)

7. Section 7 of P.L.2001, c.295 (C.17B:27A-19.9) is amended to read as follows:

7. a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide benefits to any person covered thereunder for expenses incurred in conducting a colorectal cancer screening [at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available] 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] recently published [guidelines] recommendations of the [American Cancer

Society] United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.]

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

d. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2001, c.295, s.7)

8. Section 8 of P.L.2001, c.295 (C.26:2J-4.24) is amended to read as follows:

8. a. Every enrollee agreement that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), 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 health care services to any enrollee or other person covered thereunder for expenses incurred in conducting a colorectal cancer screening [at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available] 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] recently published [guidelines] recommendations of the [American Cancer Society] United States Preventive Services Task Force and as determined medically necessary by the covered person's physician, in consultation with the covered person.

[As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.**]**

b. 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.

c. The health care services shall be provided to the same extent as for any other medical condition under the enrollee agreement.

d. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

(cf: P.L.2012, c.17, s.273)

9. (New section) 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 benefits to any person covered thereunder 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.

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the contract.

10. (New section) 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 benefits to any person covered thereunder 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.

b. 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.

c. The benefits shall be provided to the same extent as for any other medical condition under the contract.

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

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 subsection a.(5) 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; **[**and**]**

(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; and

(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.

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 form 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 provided 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 33 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 subsections a.(1), (3), and (5) of this section and subsections b.(1)-(10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

(5) (a) Inpatient hospital services, subsection a.(1) 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, subsection a.(2) 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 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.

(cf: P.L.2019, c.473)

12. This act shall take effect on the first day of the fourth month next following enactment and shall apply to policies and contracts that are delivered, issued, executed, or renewed on or after that date.

STATEMENT

This bill requires health insurance coverage of colorectal cancer screenings recommended by the United States Preventive Services Task Force (USPSTF) and eliminates cost-sharing requirements for colonoscopies performed following a positive result on a non-colonoscopy, colorectal cancer screening test.

Presently, health benefit plans are only required to cover a colorectal cancer screening at regular intervals for a person who is aged 50 and over, or for a person of any age who is considered to be at high risk for colorectal cancer.

Under this bill, health insurance carriers (including health service corporations, hospital service corporations, medical service corporations, health maintenance organizations authorized to issue health benefits plans in New Jersey, entities contracted to administer health benefits in connection with the State Health Benefits Program or School Employees' Health Benefits Program, and the Medicaid Program) will be required to cover a colorectal cancer screening recommended by the USPSTF. The bill also eliminates cost-sharing requirements for colonoscopies performed following a positive result on a non-colonoscopy, colorectal cancer screening test recommended by the USPSTF.

Appendix II

NEW JERSEY GENERAL ASSEMBLY

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MEMBER
FINANCIAL INSTITUTIONS AND INSURANCE, CHAIR
APPROPRIATIONS
ENVIRONMENT AND SOLID WASTE
INTERGOVERNMENTAL RELATIONS COMMISSION

May 25, 2022

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, NJ 08625

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institutions and Insurance Committee, I respectfully request the Commission to review and prepare a written report of A-3523 which requires health insurers to cover colorectal cancer screenings recommended by United States Preventive Services Task Force and eliminates cost-sharing requirements for certain colonoscopies.

If you have any questions, please do not hesitate to contact Mark Iaconelli, Jr., Esq., Deputy General Counsel, at 609-847-3500. Thank you for your immediate attention to this matter.

Sincerely,

John F McKeon

John F. McKeon

CC: Mark Iaconelli, Jr., Esq.
Deputy General Counsel
Assembly Majority Office