A STUDY OF NEW JERSEY ASSEMBLY BILL 5341

REQUIRES HEALTH INSURANCE COVERAGE OF SCREENING FOR ALZHEIMER'S DISEASE AND RELATED DISORDERS FOR CERTAIN COVERED PERSONS

Report to the New Jersey Assembly

November 7, 2025

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A5341 (see Appendix I for a copy of the legislation), a bill that requires certain insurers to "provide coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older." The bill would apply to health insurance carriers, including insurance companies, health service corporations, hospital service corporations, medical service corporations, individual health insurance policies, group health insurance policies, small employer health benefits plans, health maintenance organizations, and the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP).

A5341 states that "benefits shall be provided to the same extent as for any other condition under the contract." The bill also defines "Alzheimer's disease and related disorders" as "forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning."

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 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.

MEDICAL EVIDENCE

The most common forms of Alzheimer's Disease and Alzheimer's Disease Related Dementias (AD/ADRD) include Alzheimer's Disease, Lewy Body Dementia (LBD), Vascular contributions to cognitive impairment and dementia (VCID), Multiple-Etiology Dementias (MED) or Mixed Dementia, and Frontotemporal Dementia (FTD).[i] Dementia affects over 6 million people in the United States, with the most common type being Alzheimer's Disease, making up 60-80% of dementia cases.[ii] Even though AD is the most common type of dementia, ADRDs share many cognitive and pathological characteristics, making them difficult to distinguish in some cases.[iii] The information in Table 1 highlights an overview, common symptoms, and the diagnosis methods for AD/ADRD.

Table 1. AD/ADRD Information

Disease	Overview	Symptoms	How its diagnosed
Alzheimer's Disease [1]	Buildup of proteins in the forms of amyloid plaques and neurofibrillary tangles in the brain.	Memory loss, repeating statements and questions over and over, trouble concentrating and thinking, trouble making sensible decisions, changes in personality and behavior.	It's important to be able to explain symptoms, helpful to get input from family or friends. Blood tests, brain scans, biomarkers, physical, neurological, and neuropsychological exams.
Lewy Body Dementia [2]	Second most common type of dementia. Caused by a buildup of Lewy body proteins in the brain leading to gradual decline in ability to think.	Visual hallucinations, slowed movement, rigid movements, loss of bladder control, memory loss, confusion, and sleep issues.	Neurological and physical exam (check for signs of Parkinson's disease), test of mental abilities, brain scans, sleep test, autonomic function test.
Vascular contributions to cognitive impairment and dementia [3]	Issues with reasoning, planning, judgment, memory, etc. Caused by brain damage from abnormal blood flow to the brain, such as a stroke.	Confusion, trouble paying attention and concentrating, unsteady gait, memory loss, difficulty with organization and deciding what to do next.	No specific test, but doctors will determine diagnosis based on information provided, medical history, and the help of lab tests, neurological exams, brain scans, neuropsychological tests.
Frontotemporal Dementia[4]	Umbrella term for a group of brain diseases affecting the frontal and temporal lobes of the brain. These areas are associated with personality, behavior and language.	Symptoms differ from person to person. Symptoms tend to occur together, and patients can have more than one cluster of symptoms. Symptoms include: Inappropriate social behavior, loss of interpersonal skills, overeating, trouble with written and spoken language, loss of semantics, mistakes in sentence building.	No specific test. Medical professionals will consider symptoms and rule out other causes for symptoms. Blood tests, sleep study, neuropsychological testing, and brain scans can be done.

Multiple-Etiology [5] Dementias or Mixed Dementia [6]	Multiple different abnormal protein deposits and pathologies contributing to symptoms.	Identical to AD or another type of dementia. However, symptoms vary depending on extent of brain changes.	Hard to diagnose while alive, often found during autopsies. Patients are usually diagnosed with one type of dementia while alive.

[1] Mayo Clinic, "Alzheimer's Disease," November 8, 2024. Accessed 7/22/25. Alzheimer's disease

[2] Mayo Clinic, "Lewy Body Dementia," June 21, 2025. Accessed 8/6/25. Lewy body dementia

[3] Mayo Clinic, "Vascular Dementia," July 29, 2021. Accessed 8/6/25. Vascular dementia

[4] Mayo Clinic, "Frontotemporal Dementia," November 28, 2023. Accessed 8/7/25. Frontotemporal dementia

[5] National Institute of Neurological Disorders and Stroke, "Focus on Multiple-Etiology Dementias (MED) Research," April 15, 2025. Accessed 8/7/25. Multiple-Etiology

[6] WebMD, "Mixed Dementia," July 15,2024. Accessed 8/7/25. Mixed Dementia

There are many overlaps among the various forms of dementia, from symptoms to diagnostic methods. While each type has its own distinct features, AD is the most common form and discussions about dementia often focus on Alzheimer's. In this context, Alzheimer's is typically described in terms of five stages, each reflecting a progression in symptom severity.[iv] It is important to note that the stages provide a general idea of what symptoms can be experienced. Symptoms and stages may overlap and include:

Preclinical Alzheimer's Disease: The disease can be identified before any symptoms surface through imaging that can detect biomarkers and protein deposits indicating Alzheimer's disease.[v]

Mild Cognitive Impairment (MCI) due to Alzheimer's Disease: AD doesn't always cause MCI, but sometimes, MCI can indicate AD with symptoms including memory loss and difficulty planning and making sensible decisions. People can still work and carry out daily tasks, however symptoms may become noticeable to others.[vi]

Mild dementia due to Alzheimer's Disease: Symptoms include difficulty thinking, remembering words or names, frequently misplacing items, forgetting material that was just read, and inability to organize, plan, and perform tasks in a work or social setting. At this point family and friends will notice the distinct symptoms occurring. [vii,viii]

Moderate dementia due to Alzheimer's Disease: At this point, loss of daily functions occurs, such as washing and dressing properly for the season. Additionally, forgetting elements of personal past, confusion about time and place, trouble controlling bladder and bowels, changes in sleep patterns, mood swings, withdrawal, suspicion or delusional thoughts about others, or agitated/aggressive behavior. [ix,x]

Severe dementia due to Alzheimer's Disease: Individuals lose the ability to respond to their environment and carry on a conversation, as well as experiencing changes in walking, sitting, and eventually swallowing. Due to severe symptoms, individuals require around-the-clock assistance.[xi]

Even though individuals with AD forget how to do many things, skills like reading, storytelling, dancing, singing, and tying shoes may be maintained because these are stored in a different part of the memory.[xii]

The cause of AD is not fully understood; however, current evidence points to genetic, lifestyle, and environmental components.[xiii,xiv,xv] What is known is that Tau, a protein, forms twisted fibers inside the neurons contributing to poor communication inside.[xvi] Another protein, beta-amyloid, builds up and takes up the space between the neurons in the brain, preventing normal communication between neurons.[xvii] Individuals with Down Syndrome are at a higher risk of developing AD since they have three copies of the gene that creates beta-amyloid protein.[xviii] Some other risk factors include age, sex, family history, MCI, head trauma, air pollution, excessive alcohol use, and certain medical conditions like diabetes, heart issues, and history of strokes.[xix]

Alzheimer's disease currently has no cure, so treatment focuses on improving the quality of life for individuals who have the condition.[xx] Medications used in the management of AD include cholinesterase inhibitors, memantine, and amyloid-beta targeting therapies such as lecanemab-irmb and donanemab-azbt for slowing or delaying memory lapse and other cognitive changes.[xxi] These medications tend to be most effective in the early or middle stages of AD.[xxii] Research supports genetic testing for the APOE ε4 gene prior to initiating amyloid-targeting therapies, as individuals with two copies of the APOE ε4 gene are at a significantly higher risk for treatment-related complications, including amyloid-related imaging abnormalities (ARIA).[xxiii]

There is no specific screening test for AD. The screening tools available involve a variety of brief assessments designed to detect cognitive impairment. There are patient assessment tools as well as informant (family and friends) assessment tools.[xxiv] Mini-Mental State Examination (MMSE) is one of the most common patient assessment tools. It is a 30-point questionnaire designed to evaluate various cognitive functions.[xxv] Other screening assessments for patients include the clock drawing test (CDT), Mini-Cog verbal fluency, Functional Activities Questionnaire (FAQ), and Abbreviated Mental Test (ABT), among others.[xxvi] Informant tools consist of assessments like the 8-Item Informant Interview (AD8), Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), Montreal Cognitive Assessment (MoCA), and the General Practitioner Assessment of Cognition (Part 1).[xxvii,xxviii] If any of these assessments results in a positive finding, additional diagnostic testing is recommended to provide a formal diagnosis.[xxix]

The United States Preventive Services Task Force (USPSTF) is a scientifically independent, volunteer panel of national experts in disease prevention and evidence-based medicine that makes evidence-based recommendations about clinical preventive services that help inform how various health care services and treatments are covered by insurance.[xxx] With the many screening

assessments available, the USPSTF grades screening for cognitive impairment an "I statement" rating, signifying that current evidence for the service is insufficient and a balance between the benefits and harms cannot be determined.[xxxi] USPSTF grading typically follows an A-to-D scale, where an A indicates that the USPSTF strongly recommends the service due to a substantial net benefit, while a D signifies that the USPSTF advises against the service because it offers no net benefit, or its harms outweigh the benefits.[xxxii] It is important to note that even though screening for cognitive impairment currently has an "I statement," the USPSTF has advised that it is in the process of updating its recommendation.[xxxiii] The USPSTF's draft research plan was posted for public comment on its website from March 6, 2025, through April 2, 2025.[xxxiv] The comment period is now closed. The USPTF will work towards a draft recommendation and draft evidence review, which will be open to further public comment, before moving to final recommendation.

The rating of a preventive service has consequences for existing coverage requirements. The Patient Protection and Affordable Care Act (ACA), Section 2713, amending the Public Health Services Act, regulations implementing the ACA, and state law set forth at P.L.2019. c. 360, currently require carriers to provide coverage for certain preventive services. Specifically, with regard to preventive service coverage mandates, the ACA requires coverage of evidence-based items or services that have an "A" or "B" recommendation rating from the USPSTF, based on clear empirical evidence of their efficacy. Since the USPSTF rating of AD screening is an "I" it does not trigger coverage requirements under state or federal law.

SOCIAL IMPACT

Arguments against AD/ADRD screening focus on the concern for the psychological impact on people diagnosed with a cognitive disorder with only marginally beneficial therapies available.[xxxv] However, there is some evidence that, if diagnosed early, an individual with AD may be able to preserve daily functioning for some time because the person will be able to start medication earlier.[xxxvi] Additionally, screening may also benefit families, granting them time to plan for the future by getting ahead on financial and legal matters, tending to potential safety issues, starting to learn about long-term care options, and beginning to develop support networks.[xxxvii] By way of example, a study of 406 spousal caregivers of individuals with AD evaluated the effectiveness of a counseling and support intervention versus standard care.[xxxviii] The intervention included individual and family counseling sessions, participation in support groups, and access to on-demand telephone counseling. Caregivers completed structured questionnaires at regular follow-up intervals.[xxxix] Findings from the trial revealed that individuals with AD had a 28.3% lower rate of nursing home placement when their spouses received counseling and support intervention compared to those receiving usual care.[xl] Nursing home placement was delayed by a predicted median of 557 days.[xli] The authors concluded that, with focus and greater access to effective counseling and support caregiver programs, there is potential to yield significant benefits for both caregivers and individuals with AD.[xlii]

Another study challenges claims against screening for AD/ADRD by assessing the costs and benefits of early detection, treatment, and ongoing management of AD patients.[xliii] Using long-term care (LTC) costs data from Wisconsin and data about pharmacologic and nonpharmacologic therapies, the authors found that early detection and management of individuals with AD yielded cost savings utilizing various models and parameters.[xliv] Net social benefits (money saved) were greatest when AD was diagnosed earlier and when caregiver intervention programs were used alongside drug therapy. The authors also assessed the potential net social benefit of implementing a more effective drug therapy compared to existing treatments, and projected additional cost savings at the individual, state, and federal levels.[xlv] Since most individuals with dementia are aged 65 and older, treatment typically falls under Medicare coverage.[xlvi] While most drug therapies are reimbursed through Medicare, caregiver programs are not.[xlvii] Although the study reports benefits associated with caregiver interventions, these programs are not currently funded under Medicare. The authors conclude that increasing access to programs and therapies supported by research may yield benefits at multiple levels.[xlviii]

While there is some evidence that screening may benefit patients, AD/ADRD is often undiagnosed in primary care, despite the availability of many cognitive assessment tools.[xlix] This issue is more prevalent among older Black and Hispanic people than their White counterparts.[l] One explanation for this difference is that many cognitive test were developed in White populations and therefore, the assessments do not accurately account for cultural or health differences.[li] Black people face the highest risk of developing AD, followed by American Indian and Latino populations.[lii] This increased risk is largely due to disparities in access to quality health care and essential resources such as nutritious food and clean air.[liii] Certain risk factors associated with AD, such as diabetes and air pollution, typically affect these minority populations at a higher rate when compared with White populations; these risk factors may also disproportionately affect those who are socioeconomically disadvantaged.[liv] As a result, despite their elevated risk, minority populations are less likely to be appropriately screened for Alzheimer's disease, leading to delayed or missed diagnoses, particularly in primary care settings.[lv]

To promote greater equity in screening for AD/ADRD, researchers created the 5-Cog paradigm.[lvi] This is a culturally sensitive, non-literacy-based cognitive assessment that takes five minutes to complete. It is integrated with an electronic medical record (EMR) system and includes a clinical decision tree to support primary care providers in making informed dementia care actions.[lvii] In a study, 1,201 patients from marginalized communities experiencing health disparities were randomly assigned to the 5-Cog paradigm treatment group or to a control group.[lviii] When tested within 90 days, the 5-Cog paradigm group had triple the likelihood of dementia care intervention (*i.e.,* more diagnoses, follow up laboratory tests or imaging, and specialist referrals). The 5-Cog paradigm effectively alleviated the many issues with other AD/ADRD screening methods it attempted to address. The 5-Cog paradigm increased dementia care actions in underserved communities without increasing adverse events; the 5-Cog paradigm is also easily deployable (*i.e.,* it could be administered by non-physicians).[lix] Results remained consistent across all subgroups,

demonstrating this assessment's potential to minimize existing disparities in dementia diagnosis and allow increased AD/ADRD screening access.[lx]

OTHER STATES

No other state has enacted or introduced legislation that, like A5341, would seek to extend commercial insurance coverage of screening for Alzheimer's disease and related disorders to subscribers 65 years of age or older.

In terms of related legislation, rather than focusing directly on screening for AD/ADRD, the Alzheimer's Impact Movement (AIM) has joined a national coalition to advocate for expanded insurance coverage for biomarker testing.[lxi] These coalition organizations, which include the American Cancer Society-Cancer Action Network, the Arthritis Foundation, and the ALS (Amyotrophic lateral sclerosis) Association, contend that requiring insurance coverage for biomarker testing encompasses the screening and testing procedures needed to diagnose each of the specific diseases for which they advocate. AIM suggests that the strategy of supporting the expansion of state insurance coverage of biomarker testing, including for AD/ADRD, can "reduce the time it takes to receive a diagnosis and make it easier to access new disease- modifying treatments and care planning."[lxii]

New Jersey enacted a biomarker testing law on April 23, 2025,[lxiii] although the insurance mandate excludes coverage for screening of asymptomatic patients. Accordingly, New Jersey's biomarker testing law could require health benefits coverage for biomarker testing for ADRD in some cases. However, for the existing biomarker coverage mandate to apply, the patient would likely need to have some symptoms of the condition, coverage would not apply other types of ADRD screenings beyond biomarker testing, and coverage would not be limited to those who are age 65 and older, as it would under A5341.

Coverage mandates for biomarker testing have been adopted in 21 other states; as with New Jersey's law, those mandates may cover biomarker testing for ADRD in some cases. However, because the scope, requirements, and restrictions in those laws vary from state to state, an individual analysis would be necessary to determine the extent to which ADRD would fall within a given state's biomarker testing coverage mandate, and as with New Jersey's law, even if a biomarker testing mandate would apply to ADRD in some cases, it would not cover other forms of ADRD screening.[lxiv,lxv,lxvi,lxvii,lxviii,lxix,lxx,lxxi]

As such, legislation comparable to A5341 has not been introduced in any other state.

DISCUSSION

Currently no New Jersey insurance carriers provide coverage for screening of asymptomatic patients either over or under the age of 65 years for the purpose of detecting AD/ADRD. Typically, comprehensive screening of asymptomatic patients for AD/ADRD is covered under Medicare (which provides health benefits coverage for individuals age 65 and above) and is part of the annual wellness visit (AWV). Anyone covered under Medicare Part B for at least 12 months qualifies for a wellness visit that includes routine measurements like height, weight, and blood pressure, a review of personal and family medical history, a review of current prescriptions, and a screening schedule of preventive services.[lxxii] The covered person also completes a "Health Risk Assessment" questionnaire and receives a cognitive assessment. The healthcare provider will "look for signs of dementia, including Alzheimer's disease…." and "cognitive impairment includ[ing] trouble remembering, learning new things, concentrating, managing finances, and making decisions about everyday life."[lxxiii] Assessing cognitive impairment in the covered person is "a required element of Medicare's Annual Wellness Visit (AWV)." [lxxiv]

If the provider detects signs of cognitive impairment, Medicare Part B covers a separate visit entailing a fuller cognitive assessment and the development of a care plan. During the cognitive assessment, the healthcare provider will conduct a series of a standardized testing instruments to measure the patient's performance of activities of daily living, staging of dementia, and screening for depression and anxiety. This second evaluation is designed to allow the healthcare provider to make a more detailed assessment, including diagnosing dementia, AD, and associated conditions such as anxiety and depression, as well as making a referral to a specialist.[lxxv] The cognitive assessment must include someone in addition to the patient – such as a spouse, child, guardian, or caregiver – to corroborate or provide more accurate health and family history information and help the healthcare provider identify support resources and develop a care plan.[lxxvi]

There is evidence that the cognitive assessment protocol is underutilized in Medicare's fee-for-service program (*i.e.*, traditional Medicare), and that there are significant differences in providers' use of cognitive assessments for different groups of beneficiaries. A United States Government Accountability Office (GAO) study of cognitive assessments in traditional Medicare from 2018 through 2022 found, for example, that "at most, in 2021, about 2.4 percent of traditional Medicare beneficiaries with a diagnosis of Alzheimer's disease or a related disorder may have received the….cognitive assessment service…."[lxxvii]

Furthermore, the GAO study reported that delivery of cognitive assessment services varied significantly by beneficiary characteristics, with urban, female, and older beneficiaries significantly more likely to receive cognitive assessment services than rural, male, and relatively younger beneficiaries.[lxxviii] The study found that, "Urban providers delivered more than 90 percent of cognitive assessment service visits…." while "only 7.5 percent of these services were delivered by rural providers."[lxxix] Female beneficiaries' use of cognitive assessment services rose from 94 per 100,000 beneficiaries in 2018 to 325 per 100,000 beneficiaries in 2022, while for men the

numbers for the same period rose from 72 per 100,000 to 242 per 100,000 beneficiaries.[lxxx] Perhaps the most important finding from the GAO report in terms of the financial impact of screening for AD/ADRD was that the age group with the greatest utilization of cognitive assessment services was beneficiaries age 85 years and older. Those implications of these findings are discussed in the next section of this report.

In short, screenings for AD/ADRD for those over age 65 are already covered under Medicare and are part of the annual wellness visit; however, research suggests the screenings are potentially under-utilized. The coverage mandate that would be established under A5341 would potentially expand the number of individuals being screened for AD/ADRD; however, that depends on the extent to which people covered under Medicare continue to maintain coverage under a health benefits plan that would fall under the A5341 coverage mandate, and it is not clear that individuals who are not currently receiving the Medicare-covered screening would receive the screening if covered under a different health benefits plan.

FINANCIAL IMPACT

There are a number of goals in screening for, diagnosing, and treating AD/ADRD. Among these are the detection of potentially reversible causes of cognitive impairment, maximizing function in daily activities and maintaining quality of life, and delaying institutionalization as long as possible.[lxxxi,lxxxii] One study suggested, "Early detection may also enable patients to communicate living and end-of-life desires before impairment is severe and allow families to plan for a patient's safety and protection."[lxxxiii] Another study found, "Early diagnosis of AD and the subsequent access to treatments, enrollment in clinical trials, and adjustment of modifiable risk factors may contribute to improved patient care…."[lxxxiv]

It should be noted that A5341 would require certain health benefits plans to provide coverage for AD/ADRD screenings. In most cases, this will be limited to covering the costs to administer one of several available tests or assessments for cognitive impairment. However, as discussed above, expanded access to AD/ADRD screenings may facilitate earlier diagnosis, which can potentially enable patients and their families to access resources and services earlier, which could potentially reduce some of the costs of treatment, delay the need for nursing home care, and reduce some of the costs and challenges to caregivers. Although these prospective cost effects are too abstract to attempt to quantify in this report, the following discussion outlines some of the costs associated with AD/ADRD treatment that may potentially be affected by earlier diagnoses resulting from an expanded coverage mandate.

The cost of treating AD/ADRD is growing markedly. Those costs can be divided into direct and indirect costs, with the direct costs further subdivided into direct medical and direct non-medical costs.[lxxxv] Direct medical costs for treating AD/ADRD include "physician office visits, hospital

admissions, emergency department visits, skilled nursing care, and medications," with long-term care in nursing homes and home healthcare services representing the majority of these direct costs.[lxxxvi] Direct nonmedical costs become greater as the dementia progresses and patients require additional home health supervision, home safety modifications, more full-time residential services, transportation assistance, and other forms of personal care.[lxxxvii] Finally, the indirect costs of treating AD/ADRD include "costs associated with premature death, loss of productivity, and informal unpaid care costs…that are predominantly borne by the patient's family or caregiver."[lxxxviii]

Estimates of direct medical costs for treating AD/ADRD in the United States have risen from $290 billion in 2019,[lxxxix] to $321 billion in 2022,[xc] to $384 billion in 2025.[xci] While an estimated 4% of people 80 years of age will be living in a nursing home, roughly 75% of people with AD are estimated to be living in a nursing facility;[xcii] this has profound implications for the direct medical costs of treating AD/ADRD. A study reported, "The average total annual costs in 2021 dollars for Medicare beneficiaries 65 years and older with AD or other dementias have been estimated to be $41,757, which is about 3 times higher than those without AD ($14,026)."[xciii] The Alzheimer's Association estimated that, in 2024 dollars, New Jersey's Medicaid program would make payments of $2.835 billion for care for patients aged 65 years and older living with AD/ADRD.[xciv]

As for direct non-medical and indirect costs of care for AD/ADRD, one study reported that dementia caregivers paid approximately twice the average out-of-pocket costs paid by non-dementia caregivers ($12,388 versus $6,667).[xcv] Those out-of-pocket costs were estimated to amount to $97 billion, representing an estimated 25% of the total cost of care.[xcvi] It was also reported that, in 2022, "an estimated 11.3 million family and unpaid caregivers of individuals with AD or other dementias provided an estimated 16 billion hours of…unpaid…assistance valued at approximately $271.6 billion."[xcvii]

As another study elaborated, "Caregiving for patients with AD is unique compared with caregiving in other disease states due to the long duration of the disease, and the progressive, unrelenting decline in cognitive and physical functioning."[xcviii] Caregivers for patients with AD/ADRD primarily assist with activities of daily living, but may also help the patient handle financial affairs, act as a healthcare advocate, help oversee medication compliance, deal with the behavioral symptoms of the disease, and help organize adult day care programs and in-home care.[xcix]

These physical and financial demands may take a serious toll on unpaid caregivers of AD/ADRD patients. These caregivers "are more likely to experience disruptions to their work schedule, reduce hours worked, or leave the workforce."[c] Furthermore, the "high burden of care over a long period of time" can compromise their mental and physical health, with caregivers at higher risk for cardiovascular disease, diabetes, obesity, cancer, and depression.[ci]

Currently, carriers in New Jersey do not cover screening for AD/ADRD in asymptomatic patients. Therefore, it may be expected that mandating coverage for screening for Alzheimer's disease and

related disorders for covered persons 65 years of age or older will increase costs to carriers and result in higher insurance premiums. The magnitude of these increased costs is mitigated to some degree by the expected small number of insured people in this age group who are not already covered by Medicare, or who are covered by both Medicare and a state-regulated health benefits plan. Where a patient has both Medicare coverage and commercial market coverage subject to this bill, the benefits would be subject to coordination of benefit rules, further impacting the potential cost of A5341. Increased costs to carriers may also be offset by reduced costs resulting from earlier detection and treatment, although it is not possible to quantify the amount of any such cost reductions. No fiscal impact statements or financial notes from other states were identified to assist the MHBAC in estimating these costs.

An additional consideration is that the federal Patient Protection and Affordable Care Act requires states to defray the cost of any health insurance benefit mandate enacted after December 31, 2011, that is part of an insurance plan sold on a state exchange that is in addition to the state's essential health benefits (EHBs) and related to specific care, treatment, or services, by making the appropriate payment directly to an enrollee or to the insurer on the enrollee's behalf (P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170). A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state's exchange to the state. Defrayment does not apply to the large group market. For more information on State-required benefits, please refer to this CMS FAQ on Defrayal of State Additional Required Benefits.[cii] As part of the HHS Notice of Benefit and Payment Parameters for 2025, for plan years beginning on or after January 1, 2027, CMS revised the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process.[ciii] The process of updating the state's EHB-benchmark plan could create a pathway to adding benefits to the benchmark plan that may not trigger defrayal, provided certain parameters are met. Thus, although this is a state-by-state analysis and no such analysis has been performed for New Jersey, a coverage mandate that requires health insurance coverage of screening for Alzheimer's disease and related disorders for covered persons 65 years of age or older may trigger the federal defrayment requirements.

CONCLUSION

A5341 proposes to establish coverage requirements for screening for Alzheimer's disease and related disorders for covered persons 65 years of age or older. One study attempting to model the impact of diagnosing and treating AD at younger ages found, "Efforts to promote the earlier identification and better management of AD patients seem to hold promise in terms of stemming the future rise in costs associated with an increasing prevalence of AD in an aging population."[civ] The authors concluded, "Our analyses suggest that the net social benefits of interventions are sufficiently large to justify even relatively expensive programs to promote early diagnosis and treatment."[cv] A5341's coverage requirements only extend to subscribers aged 65 years or older.

Medicare's AWV currently requires screening of asymptomatic subscribers for signs of cognitive impairment, dementia, or AD. If a provider identifies signs of cognitive decline, Medicare covers additional assessments and testing to diagnose the specific cause and formulate a detailed plan for care and treatment of the disease. Therefore, A5341 would mandate insurance coverage for screening for AD/ADRD in a population that, generally, already has these screenings covered under Medicare.

The MHBAC is not able to estimate the cost of implementing A5341. It is probable that mandating coverage for screening for Alzheimer's disease and related disorders for covered persons 65 years of age or older will result in increased costs to New Jersey's carriers in the private market, which in turn may result in higher health premiums; however, those increased costs would likely be limited to the extent that screenings for this population are generally already covered under Medicare under circumstances where Medicare is the primary payer and by the likelihood that treatment costs will be lower for individuals for whom AD/ADRD is diagnosed earlier. Where Medicare is the secondary payer, the bill would effectively transfer the costs of screening from Medicare to New Jersey's commercial market payers.

ENDNOTES

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ASSEMBLY, No. 5341

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 20, 2025

Sponsored by:
Assemblywoman LINDA S. CARTER
District 22 (Somerset and Union)
Assemblywoman VERLINA REYNOLDS-JACKSON
District 15 (Hunterdon and Mercer)
Assemblyman ROBERT J. KARABINCHAK
District 18 (Middlesex)

Co-Sponsored by:
Assemblywoman Quijano

SYNOPSIS

Requires health insurance coverage of screening for Alzheimer's disease and related disorders for certain covered persons.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 2/25/2025)

AN ACT concerning health insurance coverage of screening for Alzheimer's disease and related disorders and supplementing various parts of the statutory law.

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

1. a. A hospital service corporation contract that provides hospital and 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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

2. a. A medical service corporation contract that provides hospital and 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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

3. a. A health service corporation contract that provides hospital and 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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those health service corporation contracts in which the health service corporation has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

4. a. An individual health insurance policy that provides hospital and medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S.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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those individual health insurance policies in which the insurer has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

5. a. A group health insurance policy that provides hospital and 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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those group health insurance policies in which the insurer has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

6. a. An individual health benefits plan that provides hospital and 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 by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those health benefits plans in which the carrier has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

7. a. A small employer health benefits plan that provides hospital and 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 by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those health benefits plans in which the carrier has reserved the right to change the premium.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

8. a. A health maintenance organization contract for health care services that 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 coverage for screening for Alzheimer's disease and related disorders for a covered person who is 65 years of age or older.

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

c. This section shall apply to those contracts for health care services under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

d. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

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 and medical expense benefits shall provide coverage for screening for Alzheimer’s disease and related disorders for a covered person who is 65 years of age or older.

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

c. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

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 and medical expense benefits shall provide coverage for screening for Alzheimer’s disease and related disorders for a covered person who is 65 years of age or older.

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

c. As used in this section, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

11. This act shall take effect on the 180th day following enactment, and shall apply to contracts delivered, issued, executed, or renewed on or after that date.

STATEMENT

This bill requires health insurance carriers (insurance companies, health, hospital, and medical service corporations, health maintenance organizations, and State and School Employees' Health Benefits Program contracts) to provide coverage for screening for Alzheimer’s disease and related disorders for a covered person who is 65 years of age or older.

As used in the bill, "Alzheimer's disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

Appendix II

NEW JERSEY GENERAL ASSEMBLY

ROY FREIMAN

ASSEMBLYMAN

16TH DISTRICT

390 AMWELL ROAD, SUITE 301
HILLSBOROUGH, NJ 08844
EMAIL: asmfreiman@njleg.org
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COMMITTEES
CHAIR, FINANCIAL INSTITUTIONS AND INSURANCE
VICE CHAIR, OVERSIGHT, REFORM AND FEDERAL RELATIONS
BUDGET

June 12, 2025

NJ 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 review and prepare a written report of A5341, which requires health insurance coverage of screening for Alzheimer's disease and related disorders for certain covered persons.

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,

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