

**SENATE, No. 2305**

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**STATE OF NEW JERSEY**

**220th LEGISLATURE**

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INTRODUCED MARCH 21, 2022

**Sponsored by:**

**Senator VIN GOPAL**

**District 11 (Monmouth)**

**Senator LINDA R. GREENSTEIN**

**District 14 (Mercer and Middlesex)**

**Co-Sponsored by:**

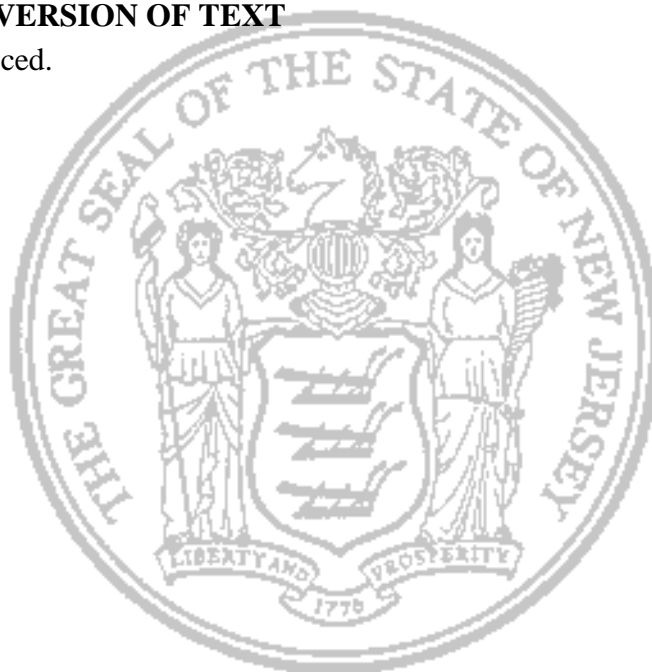
**Senators Corrado, Codey, Diegnan, Madden, Lagana, Zwicker, A.M.Bucco, Cryan, Holzapfel, Schepisi, Singer, Bramnick, Pou and Turner**

**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: 12/19/2022)**

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

4  
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*  
6 *of New Jersey:*

7  
8 1. Section 1 of P.L.2001, c.295 (C.17:48-6y) is amended to  
9 read as follows:

10 1. a. Every hospital service corporation contract that provides  
11 hospital or medical expense benefits and is delivered, issued,  
12 executed or renewed in this State pursuant to P.L.1938, c.366  
13 (C.17:48-1 et seq.), or approved for issuance or renewal in this State  
14 by the Commissioner of Banking and Insurance on or after the  
15 effective date of this act, shall provide benefits to any named  
16 subscriber or other person covered thereunder for expenses incurred  
17 in conducting a colorectal cancer screening **[at regular intervals for**  
18 **persons age 50 and over and for persons of any age who are**  
19 **considered to be at high risk for colorectal cancer. The methods of**  
20 **screening for which benefits shall be provided shall include: a**  
21 **screening fecal occult blood test, flexible sigmoidoscopy,**  
22 **colonoscopy, barium enema, or any combination thereof; or the**  
23 **most reliable, medically recognized screening test available]** in  
24 accordance with United States Preventive Services Task Force  
25 recommendations. The method and frequency of screening to be  
26 utilized shall be in accordance with the most **[recent]** recently  
27 published [guidelines] recommendations of the **[American Cancer**  
28 **Society]** United States Preventive Services Task Force and as  
29 determined medically necessary by the covered person's physician,  
30 in consultation with the covered person.

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

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

36 b. chronic inflammatory bowel disease; or

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

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

44 c. The benefits shall be provided to the same extent as for any  
45 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.**

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

4 (cf: P.L.2001, c.295, s.1)

5  
6     2. Section 2 of P.L.2001, c.295 (C.17:48A-7x) is amended to  
7 read as follows:

8     2. a. Every medical service corporation contract that provides  
9 hospital or medical expense benefits and is delivered, issued,  
10 executed or renewed in this State pursuant to P.L.1940, c.74  
11 (C.17:48A-1 et seq.), or approved for issuance or renewal in this  
12 State by the Commissioner of Banking and Insurance on or after the  
13 effective date of this act, shall provide benefits to any named  
14 subscriber or other person covered thereunder for expenses incurred  
15 in conducting a colorectal cancer screening **[at regular intervals for**  
16 **persons age 50 and over and for persons of any age who are**  
17 **considered to be at high risk for colorectal cancer. The methods of**  
18 **screening for which benefits shall be provided shall include: a**  
19 **screening fecal occult blood test, flexible sigmoidoscopy,**  
20 **colonoscopy, barium enema, or any combination thereof; or the**  
21 **most reliable, medically recognized screening test available]** in  
22 accordance with United States Preventive Services Task Force  
23 recommendations. The method and frequency of screening to be  
24 utilized shall be in accordance with the most **[recent]** recently  
25 published **[guidelines]** recommendations of the **[American Cancer**  
26 **Society]** United States Preventive Services Task Force and as  
27 determined medically necessary by the covered person's physician,  
28 in consultation with the covered person.

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

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

34     b. chronic inflammatory bowel disease; or

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

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

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

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

47 (cf: P.L.2001, c.295, s.2)

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

3       3. a. Every health service corporation contract that provides  
4 hospital or medical expense benefits and is delivered, issued,  
5 executed or renewed in this State pursuant to P.L.1985, c.236  
6 (C.17:48E-1 et seq.), or approved for issuance or renewal in this  
7 State by the Commissioner of Banking and Insurance on or after the  
8 effective date of this act, shall provide benefits to any named  
9 subscriber or other person covered thereunder for expenses incurred  
10 in conducting a colorectal cancer screening **[at regular intervals for**  
11 **persons age 50 and over and for persons of any age who are**  
12 **considered to be at high risk for colorectal cancer. The methods of**  
13 **screening for which benefits shall be provided shall include: a**  
14 **screening fecal occult blood test, flexible sigmoidoscopy,**  
15 **colonoscopy, barium enema, or any combination thereof; or the**  
16 **most reliable, medically recognized screening test available]** in  
17 accordance with United States Preventive Services Task Force  
18 recommendations. The method and frequency of screening to be  
19 utilized shall be in accordance with the most **[recent]** recently  
20 published **[guidelines]** recommendations of the **[American Cancer**  
21 **Society]** United States Preventive Services Task Force and as  
22 determined medically necessary by the covered person's physician,  
23 in consultation with the covered person.

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

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

29       b. chronic inflammatory bowel disease; or

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

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

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

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

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

43

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

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

1 this State pursuant to N.J.S. ~~17B: 23-1 et seq.~~ 17B:26-1 et seq., or  
2 approved for issuance or renewal in this State by the Commissioner  
3 of Banking and Insurance on or after the effective date of this act,  
4 shall provide benefits to any named insured or other person covered  
5 thereunder for expenses incurred in conducting a colorectal cancer  
6 screening ~~at regular intervals for persons age 50 and over and for~~  
7 ~~persons of any age who are considered to be at high risk for~~  
8 ~~colorectal cancer. The methods of screening for which benefits~~  
9 ~~shall be provided shall include: a screening fecal occult blood test,~~  
10 ~~flexible sigmoidoscopy, colonoscopy, barium enema, or any~~  
11 ~~combination thereof; or the most reliable, medically recognized~~  
12 ~~screening test available~~ in accordance with United States  
13 Preventive Services Task Force recommendations. The method and  
14 frequency of screening to be utilized shall be in accordance with the  
15 most ~~recent~~ recently published ~~guidelines~~ recommendations of  
16 the ~~American Cancer Society~~ United States Preventive Services  
17 Task Force and as determined medically necessary by the covered  
18 person's physician, in consultation with the covered person.

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

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

24 b. chronic inflammatory bowel disease; or

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

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

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

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

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

38  
39 5. Section 5 of P.L.2001, c.295 (C.17B:27-46.1y) is amended  
40 to read as follows:

41 5. a. Every group policy that provides hospital or medical  
42 expense benefits and is delivered, issued, executed or renewed in  
43 this State pursuant to N.J.S.17B:27-26 et seq., or approved for  
44 issuance or renewal in this State by the Commissioner of Banking  
45 and Insurance on or after the effective date of this act, shall provide  
46 benefits to any named insured or other person covered thereunder  
47 for expenses incurred in conducting a colorectal cancer screening

1   **【**at regular intervals for persons age 50 and over and for persons of  
2   any age who are considered to be at high risk for colorectal cancer.  
3   The methods of screening for which benefits shall be provided shall  
4   include: a screening fecal occult blood test, flexible sigmoidoscopy,  
5   colonoscopy, barium enema, or any combination thereof; or the  
6   most reliable, medically recognized screening test available**】** in  
7   accordance with United States Preventive Services Task Force  
8   recommendations. The method and frequency of screening to be  
9   utilized shall be in accordance with the most **【recent】** recently  
10   published **【guidelines】** recommendations of the **【American Cancer**  
11   **Society】** United States Preventive Services Task Force and as  
12   determined medically necessary by the covered person's physician,  
13   in consultation with the covered person.

14   **【**As used in this section, “high risk for colorectal cancer” means  
15   a person has:

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

19   b. chronic inflammatory bowel disease; or

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

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

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

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

32   (cf: P.L.2001, c.295, s.5)

33

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

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

1 most reliable, medically recognized screening test available] in  
2 accordance with United States Preventive Services Task Force  
3 recommendations. The method and frequency of screening to be  
4 utilized shall be in accordance with the most [recent] recently  
5 published [guidelines] recommendations of the [American Cancer  
6 Society] United States Preventive Services Task Force and as  
7 determined medically necessary by the covered person's physician,  
8 in consultation with the covered person.

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

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

14 b. chronic inflammatory bowel disease; or

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

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

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

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

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

28  
29 7. Section 7 of P.L.2001, c.295 (C.17B:27A-19.9) is amended  
30 to read as follows:

31 7. a. Every small employer health benefits plan that provides  
32 hospital or medical expense benefits and is delivered, issued,  
33 executed or renewed in this State pursuant to P.L.1992, c.162  
34 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this  
35 State on or after the effective date of this act, shall provide benefits  
36 to any person covered thereunder for expenses incurred in  
37 conducting a colorectal cancer screening [at regular intervals for  
38 persons age 50 and over and for persons of any age who are  
39 considered to be at high risk for colorectal cancer. The methods of  
40 screening for which benefits shall be provided shall include: a  
41 screening fecal occult blood test, flexible sigmoidoscopy,  
42 colonoscopy, barium enema, or any combination thereof; or the  
43 most reliable, medically recognized screening test available] in  
44 accordance with United States Preventive Services Task Force  
45 recommendations. The method and frequency of screening to be  
46 utilized shall be in accordance with the most [recent] recently  
47 published [guidelines] recommendations of the [American Cancer

1 Society】 United States Preventive Services Task Force and as  
2 determined medically necessary by the covered person’s physician,  
3 in consultation with the covered person.

4 【As used in this section, “high risk for colorectal cancer” means  
5 a person has:

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

9 b. chronic inflammatory bowel disease; or

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

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

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

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

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

23

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

26 8. a. Every enrollee agreement that provides hospital or  
27 medical expense benefits and is delivered, issued, executed, or  
28 renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et  
29 seq.), or approved for issuance or renewal in this State by the  
30 Commissioner of Banking and Insurance on or after the effective  
31 date of this act, shall provide health care services to any enrollee or  
32 other person covered thereunder for expenses incurred in  
33 conducting a colorectal cancer screening 【at regular intervals for  
34 persons age 50 and over and for persons of any age who are  
35 considered to be at high risk for colorectal cancer. The methods of  
36 screening for which benefits shall be provided shall include: a  
37 screening fecal occult blood test, flexible sigmoidoscopy,  
38 colonoscopy, barium enema, or any combination thereof; or the  
39 most reliable, medically recognized screening test available】 in  
40 accordance with United States Preventive Services Task Force  
41 recommendations. The method and frequency of screening to be  
42 utilized shall be in accordance with the most 【recent】 recently  
43 published 【guidelines】 recommendations of the 【American Cancer  
44 Society】 United States Preventive Services Task Force and as  
45 determined medically necessary by the covered person’s physician,  
46 in consultation with the covered person.



1       【As used in this section, “high risk for colorectal cancer” means  
2 a person has:

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

6       b. chronic inflammatory bowel disease; or

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

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

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

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

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

20  
21       9. (New section) a. The State Health Benefits Commission  
22 shall ensure that every contract purchased by the commission on or  
23 after the effective date of this act, that provides hospital or medical  
24 expense benefits shall provide benefits to any person covered  
25 thereunder for expenses incurred in conducting a colorectal cancer  
26 screening in accordance with United States Preventive Services  
27 Task Force recommendations. The method and frequency of  
28 screening to be utilized shall be in accordance with the most recent  
29 published recommendations of the United States Preventive  
30 Services Task Force and as determined medically necessary by the  
31 covered person’s physician, in consultation with the covered  
32 person.

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

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

40  
41       10. (New section) a. The School Employees’ Health Benefits  
42 Commission shall ensure that every contract purchased by the  
43 commission on or after the effective date of this act that provides  
44 hospital or medical expense benefits shall provide benefits to any  
45 person covered thereunder for expenses incurred in conducting a  
46 colorectal cancer screening in accordance with United States  
47 Preventive Services Task Force recommendations. The method and  
48 frequency of screening to be utilized shall be in accordance with the

1 most recent published recommendations of the United States  
2 Preventive Services Task Force and as determined medically  
3 necessary by the covered person's physician, in consultation with  
4 the covered person.

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

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

12

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

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

20 (1) Inpatient hospital services

21 (2) Outpatient hospital services;

22 (3) Other laboratory and X-ray services;

23 (4) (a). Skilled nursing or intermediate care facility services;

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

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

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

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

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

- 1 (2) Home health care services;
- 2 (3) Clinic services;
- 3 (4) Dental services;
- 4 (5) Physical therapy and related services;
- 5 (6) Prescribed drugs, dentures, and prosthetic devices; and
- 6 eyeglasses prescribed by a physician skilled in diseases of the eye
- 7 or by an optometrist, whichever the individual may select;
- 8 (7) Optometric services;
- 9 (8) Podiatric services;
- 10 (9) Chiropractic services;
- 11 (10) Psychological services;
- 12 (11) Inpatient psychiatric hospital services for individuals under
- 13 21 years of age, or under age 22 if they are receiving such services
- 14 immediately before attaining age 21;
- 15 (12) Other diagnostic, screening, preventative, and rehabilitative
- 16 services, and other remedial care;
- 17 (13) Inpatient hospital services, nursing facility services, and
- 18 immediate care facility services for individuals 65 years of age or
- 19 over in an institution for mental diseases;
- 20 (14) Intermediate care facility services;
- 21 (15) Transportation services;
- 22 (16) Services in connection with the inpatient or outpatient
- 23 treatment or care of substance use disorder, when the treatment is
- 24 prescribed by a physician and provided in a licensed hospital or in a
- 25 narcotic and substance use disorder treatment center approved by
- 26 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
- 27 et. seq.) and whose staff includes a medical director, and limited
- 28 those services eligible for federal financial participation under Title
- 29 XIX of the federal Social Security Act;
- 30 (17) Any other medical care and any other type of remedial care
- 31 recognized under State law, specified by the Secretary of the federal
- 32 Department of Health and Human Services, and approved by the
- 33 commissioner;
- 34 (18) Comprehensive maternity care, which may include: the
- 35 basic number of prenatal and postpartum visits recommended by the
- 36 American College of Obstetrics and Gynecology; additional
- 37 prenatal and postpartum visits that are medically necessary;
- 38 necessary laboratory, nutritional assessment and counseling, health
- 39 education, personal counseling, managed care, outreach, and
- 40 follow-up services; treatment of conditions which may complicate
- 41 pregnancy doula care; and physician or certified nurse midwife
- 42 delivery services. For the purposes of this paragraph, "doula"
- 43 means a trained professional who provides continuous physical,
- 44 emotional, and informational support to a mother before, during,
- 45 and shortly after childbirth, to help her to achieve the healthiest,
- 46 most satisfying experience possible;
- 47 (19) Comprehensive pediatric care, which may include:
- 48 ambulatory, preventive, and primary care health services. The

1 preventive services shall include, at a minimum, the basic number  
2 of preventive visits recommended by the American Academy of  
3 Pediatrics;

4 (20) Services provided by a hospice which is participating in the  
5 Medicare program established pursuant to Title XVIII of the Social  
6 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice  
7 services shall be provided subject to approval of the Secretary of  
8 the federal Department of Health and Human Services for federal  
9 reimbursement;

10 (21) Mammograms, subject to approval of the Secretary of the  
11 federal Department of Health and Human Services for federal  
12 reimbursement, including one baseline mammogram for women  
13 who are at least 35 but less than 40 years of age; one mammogram  
14 examination every two years or more frequently, if recommended  
15 by a physician, for women who are at least 40 but less than 50 years  
16 of age; and one mammogram examination every year for women  
17 age 50 and over;

18 (22) Upon referral by a physician, advanced practice nurse, or  
19 physician assistant of a person who has been diagnosed with  
20 diabetes, gestational diabetes, or pre-diabetes, in accordance with  
21 standards adopted by the American Diabetes Association:

22 (a) Expenses for diabetes self-management education or  
23 training to ensure that a person with diabetes, gestational diabetes,  
24 or pre-diabetes can optimize metabolic control, prevent and manage  
25 complications, and maximize quality of life. Diabetes self-  
26 management education shall be provided by an in-State provider  
27 who is:

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

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

43 (b) Expenses for medical nutrition therapy as an effective  
44 component of the person's overall treatment plan upon a: diagnosis  
45 of diabetes, gestational diabetes, or pre-diabetes; change in the  
46 beneficiary's medical condition, treatment, or diagnosis; or  
47 determination of a physician, advanced practice nurse, or physician  
48 assistant that reeducation or refresher education is necessary.

1 Medical nutrition therapy shall be provided by an in-State provider  
2 who is a dietitian registered by a nationally-recognized professional  
3 association of dietitians, or a nutritionist holding a certified  
4 nutritionist specialist (CNS) credential from the Board for  
5 Certification of Nutrition Specialists, who is familiar with the  
6 components of diabetes medical nutrition therapy;

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

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

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

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

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

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

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

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

42 (24) Expenses incurred for the provision of pasteurized donated  
43 human breast milk, which shall include human milk fortifiers if  
44 indicated in a medical order provided by a licensed medical  
45 practitioner, to an infant under the age of six months; provided that  
46 the milk is obtained from a human milk bank that meets quality  
47 guidelines established by the Department of Health and a licensed

1 medical practitioner has issued a medical order for the infant under  
2 at least one of the following circumstances:

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

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

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

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

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

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

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

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

46 (c) Prior authorization requirements shall not be imposed on  
47 any tobacco cessation services provided pursuant to this paragraph  
48 except in the following circumstances where prior authorization

1 may be required: for a treatment that exceeds the duration  
2 recommended by the most recently published United States Public  
3 Health Service clinical practice guidelines on treating tobacco use  
4 and dependence; or for services associated with more than two  
5 attempts to quit within a 12-month period; and

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

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

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

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

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

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

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

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

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

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

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

26 (2) In addition, any provision in a contract of insurance, health  
27 benefits plan, or other health care coverage document, will, trust,  
28 agreement, court order, or other instrument which reduces or  
29 excludes coverage or payment for health care-related goods and  
30 services to or for an individual because of that individual's actual or  
31 potential eligibility for or receipt of Medicaid benefits shall be null  
32 and void, and no payments shall be made under this act as a result  
33 of any such provision.

34 (3) Notwithstanding any provision of law to the contrary, the  
35 provisions of paragraph (2) of this subsection shall not apply to a  
36 trust agreement that is established pursuant to 42 U.S.C.  
37 s.1396p(d)(4)(A) or (C) to supplement and augment assistance  
38 provided by government entities to a person who is disabled as  
39 defined in section 1614(a)(3) of the federal Social Security Act (42  
40 31 U.S.C. s.1382c (a)(3)).

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

43 (1) Pregnant women shall be provided prenatal care and  
44 delivery services and postpartum care, including the services cited  
45 in subsections a.(1), (3), and (5) of this section and subsections  
46 b.(1)-(10), (12), (15), and (17) of this section, and nursing facility  
47 services cited in subsection b.(13) of this section.



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

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

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

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

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

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

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

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

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

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

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

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

15  
16 12. This act shall take effect on the first day of the fourth  
17 month next following enactment and shall apply to policies and  
18 contracts that are delivered, issued, executed, or renewed on or after  
19 that date.

## 20 21 22 STATEMENT

23  
24 This bill requires health insurance coverage of colorectal cancer  
25 screenings recommended by the United States Preventive Services  
26 Task Force (USPSTF) and eliminates cost-sharing requirements for  
27 colonoscopies performed following a positive result on a non-  
28 colonoscopy, colorectal cancer screening test.

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

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