A STUDY OF NEW JERSEY ASSEMBLY BILL 4642

CLARIFIES THAT TESTOSTERONE THERAPY IS COVERED TREATMENT UNDER THE "NEW JERSEY MENOPAUSE COVERAGE ACT"

Report to the New Jersey Assembly

October 23, 2026

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A4642 (see Appendix I for a copy of the legislation), a bill that "clarifies that testosterone therapy is a covered treatment under the "New Jersey Menopause Coverage Act."" The bill would apply to health insurance carriers, including large group coverage issued by commercial group health insurers, hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations, as well as individual health benefits plans, small employer health benefits plans, entities contracted to administer health benefits in connection with the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP), and the New Jersey FamilyCare Program.[*] The commercial markets regulated by the New Jersey Department of Banking and Insurance, New Jersey's Medicaid program, and the SHBP and SEHBP, in combination, cover approximately 40% of New Jerseyans.

This review of A4642 expands upon the MHBAC's analysis of A5278, the original "New Jersey Menopause Coverage Act." That bill, now enacted, required coverage "for expenses incurred in obtaining medically necessary treatment for perimenopause, menopause, and symptoms associated with perimenopause and menopause…." A5278 required that treatment include, but not be limited to:

- hormonal therapies;
- non-hormonal treatments;
- behavioral health care services;
- pelvic floor physical therapy;
- bone health treatments;
- preventive services for early detection and treatment of health conditions related to perimenopause and menopause; and
- counseling and education regarding menopause management.

The full MHBAC report on A5278 can be found here: A STUDY OF NEW JERSEY ASSEMBLY BILL 5278. This review of A4642 focuses on the impact of the bill clarifying that testosterone therapy is a covered treatment under the "New Jersey Menopause Coverage Act." Specifically, A4642 would require that, "Benefits for testosterone therapy…shall be provided to the same extent as for any hormonal treatment…and shall not be denied…if the prescribed

[*] Pursuant to the Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 et seq.), the Commission's review is limited to the application of mandates to the commercial market. Accordingly, this report does not directly address how the coverage mandate would potentially impact the Medicaid program.

therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause."

New Jersey already has an off-label coverage mandate set forth at as NJ.S.A. 17B:26-2.1g and N.J.S.A. 17:48E-35.5. Under the law, if FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia: 1. The American Hospital Formulary Service Drug Information; or 2. The United States Pharmacopeia Drug Information which recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational. In the case of testosterone, the FDA has approved it strictly for testosterone replacement therapy (TRT) in adult males who have low or absent testosterone caused by specific, recognized medical conditions (e.g., hypogonadism). It has not been approved for treatment for menopause, but it may be eligible to be covered under appropriate circumstances under New Jersey's off-label mandate.

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

A fuller discussion of the medical evidence on menopause can be found in the MHBAC report cited above. The primary insights from that report are the menopause transition period can be accompanied by a variety of physical and psychological symptoms such as hot flashes, joint and muscle discomfort, insomnia, moodiness, forgetfulness, and difficulty concentrating.[i] The Mayo Clinic notes other symptoms can include irregular periods and vaginal dryness.[ii] The intensity of these symptoms differs from person to person, and some people may not experience any symptoms at all.

A4642's focus is on testosterone therapy in women experiencing menopause. Testosterone is produced by the ovaries and adrenal glands[iii] and is "essential for bone and muscle health, sexual desire, mood, and cognitive processes."[iv] Women's testosterone levels decline as they age, a result of decreasing ovarian function and a reduction in the production of precursor hormones in the adrenal glands.[v]

Testosterone therapy has proven to be an effective treatment for postmenopausal women with hypoactive sexual desire disorder (HSDD), which is a condition involving low sexual desire that causes distress.[vi] HSDD can be diagnosed when other potential causes of low sexual desire, such as medication side effects, sleep problems, pain, relationship factors, or other possible mental health conditions, have been ruled out.[vii] A meta-analysis comparing the effects of testosterone therapy to treatment with a placebo or other hormone therapy found that postmenopausal women receiving testosterone therapy demonstrated "significantly increased sexual function," including sexual event frequency, sexual desire, pleasure, arousal, orgasm, responsiveness, and improved self-image and reduced sexual concerns, with no serious adverse side effects.[viii] However, the Mayo Clinic has noted that due to a lack of research on long-term safety, testosterone therapy shouldn't be used by women with heart, blood vessel or liver disease or those who've had breast or uterine cancer.[ix]

There are currently no federal Food and Drug Administration (FDA)-approved testosterone products for women.[x] While testosterone therapy for women can be administered in the form of injections or pellets, most practitioners find the hormone dosages delivered with these methods harder to control and more likely to cause unwanted side effects.[xi] Consequently, experts treating women with testosterone have reported they prefer to prescribe topical gels or creams designed for men, typically for daily use, and starting with a dosage that is approximately one-tenth the normal dose for a man.[xii,xiii]

When testosterone therapy is initiated or the dosage is changed, it is common for the patient to be tested three to six weeks later, and then every four to six months thereafter, to ensure the patient's hormone level is stable. As one practitioner explained, "The goal is to keep levels in a normal premenopausal range and watch for side effects."[xiv]

Other than testosterone therapy, there are two FDA-approved drugs used to treat HSDD in women, Addyi and Vyleesi. Addyi, approved by the FDA in 2015, is an oral tablet taken once daily at bedtime.[xv] Addyi was approved to treat HSDD in premenopausal women,[xvi] but there is evidence that it is also effective in treating postmenopausal women.[xvii,xviii] Researchers found that Addyi taken at a higher dosage level meaningfully improved symptoms of HSDD in roughly 50% of women.[xix] The most common side effects of Addyi were dizziness, drowsiness, nausea, fatigue, insomnia, and dry mouth, although the incidence of any of these adverse effects was 2% or less. In 2021, the out-of-pocket cost for Addyi for patients without insurance using the

manufacturer's coupon was $99 per month.[xx] Currently, patients paying with cash and using manufacturer's coupons can obtain Addyi for $149, or $20 out-of-pocket for insured patients.[xxi] Meanwhile, the average cash price for a month of Addyi (30 tablets) for patients without insurance is $2,086; each tablet costs roughly $70.[xxii]

Vyleesi, approved by the FDA in 2019, is self-administered via subcutaneous injection under the skin of the abdomen or thigh using an autoinjector pen at least 45 minutes before anticipated sexual activity. Vyleesi was also approved to treat HSDD in premenopausal women.[xxiii] Researchers reported meaningfully improved HSDD symptoms in 58.2% of the women receiving Vyleesi versus 35.6% of the women receiving placebo.[xxiv] The most common side effects with Vyleesi were nausea, flushing, headache, vomiting, and injection site reactions. Nausea was the most common side effect, with 40% of subjects receiving Vyleesi reporting the side effect. In 2021, with online discounts, the cost for a four-pack of injectors ranged from $0 for insured patients to $99 for patients without insurance paying cash.[xxv] The manufacturer's coupon program has maintained those costs in 2026,[xxvi] while the average cash price for a four-pack of injectors is now $1,411, or approximately $353 per injector.[xxvii] Another source quoted an out-of-pocket cost for Vyleesi of "about $290 per auto-injector.[xxviii]

To summarize, testosterone therapy has been proven to be an effective and safe treatment for HSDD. It has not been demonstrated to be an effective treatment for hot flashes, anxiety, insomnia, or depression, or any other menopausal symptom.[xxix] As the Global Consensus Position Statement on the Use of Testosterone Therapy for Women stated, apart from treating HSDD in postmenopausal women, "There are insufficient data to support the use of testosterone for the treatment of any other symptom or clinical condition, or for disease prevention."[xxx] There are two FDA-approved medications used to treat HSDD; they are likely to be covered by New Jersey carriers if medical providers prescribe them to treat HSDD in menopausal or postmenopausal women.

SOCIAL IMPACT

By 2030, 500 million women between 45 and 55 years of age will be perimenopausal or postmenopausal, representing 6% of the world's population.[xxxi] Given the overall variety and complexity of symptoms that may emerge during the transition to menopause, including the potential for patients to develop certain chronic conditions, the healthcare workforce may struggle to keep up with the anticipated increase in demand for treatment and treatment providers, with many providers already reporting that they lack the expertise to "effectively diagnose and manage menopausal symptoms."[xxxii]

In addition to incurring higher healthcare costs, women who are perimenopausal or menopausal frequently experience disruptions in their professional lives. Research indicates that menopausal symptoms can negatively impact job performance and engagement.[xxxiii] Extrapolating research

findings to 2020 U.S. Census data, a Mayo Clinic analysis estimated $1.8 billion is lost annually due to women missing workdays because of menopausal symptoms. This estimate may not reflect the full societal cost of menopause, as it does not include the cost effects of reduced hours of work, loss of employment, early retirement, or job switching resulting from menopausal symptoms.[xxxiv] When accounting for medical expenses, the total cost of menopausal symptoms is an estimated $26 billion each year. Reviewing a focus group comprising women age 40 and older, researchers reported that some women said they had considered leaving their jobs altogether due to "severe and disruptive symptoms" and felt their employers could not accommodate their needs.[xxxv]

Apart from being one of the medical conditions associated with menopause, no studies on the specific social impact of HSDD were identified. There is potential that the symptoms that can attend HSDD, such as impaired personal relationships, stress, anxiety, and poor self-image, can contribute to or exacerbate the elements that result in menopausal symptoms having adverse effects on women's professional lives or on the economy more broadly. However, it is not presently possible to quantify the size or nature of the impact HSDD may have on those effects.

Research suggests that menopause treatment can vary by race and income[xxxvi] with women of color less likely "to be offered or to receive standard hormone therapy, and cost, bias and medical mistrust can all play a role in those disparities."[xxxvii] Furthermore, to the extent testosterone therapy to treat HSDD is not a covered health benefit, women seeking to treat HSDD with testosterone would need to pay the full cost of the treatment, which costs would disproportionately affect women with lower incomes and resources, resulting in reduced access within that population.[xxxviii]

OTHER STATES

Five states, including New Jersey, have enacted laws mandating insurance coverage or prescription coverage for the treatment of menopause and/or prescription hormone therapy. None of these states expressly references testosterone therapy for the treatment of menopause in its coverage law.

States with Enacted Laws Mandating Coverage for Menopause Treatment

Louisiana

Louisiana was the first state to enact an insurance coverage mandate for the treatment of menopause. Louisiana's law covers both perimenopausal and menopausal care, provides for hormonal and symptomatic treatment, and requires that all health insurance issuers and the state's Medicaid program provide coverage. Louisiana's law also "explicitly banned step

therapy and prior authorization for hormone therapy…."[xxxix] This law made no specific mention of testosterone therapy as a treatment for the symptoms of menopause or perimenopause, as in A4642.

Illinois

Illinois was the second state to enact an insurance coverage mandate for the treatment of menopause, requiring commercial group and individual policies and managed care plans to cover "medically necessary hormonal and non-hormonal therapy to treat menopausal symptoms…."[xl] Coverage includes all "federal Food and Drug Administration (FDA)-approved modalities of hormonal and non-hormonal administration, including, but not limited to, oral, transdermal, topical, and vaginal rings."[xli] Finally, the law requires Illinois' Medicaid program to cover medically necessary hormonal therapy to treat menopause induced by cancer treatment, hysterectomy, or other medical conditions.[xlii] Illinois' law makes no specific reference to the use of testosterone therapy for the treatment of menopause or perimenopause symptoms, as in A4642.

Oregon

Oregon's law requires all state-regulated health benefit plans, including the state's public employee programs, to cover treatment of perimenopausal, menopausal, and postmenopausal symptoms. Oregon's law states, "The coverage required…is limited to drugs that have been approved by the United States Food and Drug Administration."[xliii] Mandated coverage also includes hormonal and non-hormonal therapies and medications to prevent or treat osteoporosis, but the law has no reference to testosterone therapy as being among covered treatments.

States with Enacted Laws Mandating Coverage for Hormone Therapy

Washington

Washington's law focuses on the prescribing of all hormonal treatments, rather than on specific therapies for treating the symptoms of menopause. Washington's mandate, which applies to state-regulated individual and group health insurance plans, requires that a covered person may obtain a 12-month supply of a prescription hormone therapy at one time. The law specifies that, "To the extent not otherwise prohibited…health plans may apply drug utilization management strategies…."[xliv] The law also stipulates "prescription hormone therapy" means all drugs approved by the FDA to "increase…or replace hormones that the body is not producing at intended levels.[xlv] In summarizing Washington's law, one policy analyst commented that this law "applies to hormone therapy broadly, including for menopause, but is a dispensing access law rather than a comprehensive coverage mandate."[xlvi]

As for New Jersey's existing mandate, one commentator surveying laws in other states opined that the "New Jersey Menopause Coverage Act" can be described as "the most comprehensive menopause insurance mandate in the country."[xlvii] The same commentator suggested that the law means that a New Jersey women covered by a state-regulated health insurance plan "can now see a menopause specialist, get a hormone prescription, begin pelvic floor therapy, and schedule a bone density scan all at standard cost-sharing rather than full out-of-pocket."[xlviii] A4642 seeks to clarify that testosterone therapy is a covered treatment for a symptom of menopause under the "New Jersey Menopause Coverage Act" and cannot be denied by an insurer as an elective or investigational therapy because the treatment has not been approved by the FDA.

DISCUSSION AND FINANCIAL IMPACT

Menopause involves a complex set of symptoms and conditions that vary widely for individual women. Some women experience few health concerns during menopause. The "New Jersey Menopause Coverage Act" established a comprehensive insurance mandate to require coverage for the range of needs for hormonal and non-hormonal therapies, physical therapy, behavioral healthcare services, bone health treatments, preventive services for early detection and treatment of health conditions related to menopause, and counseling and education regarding menopause management. A4642 seeks to clarify that insurance coverage for testosterone therapy is intended to be part of that comprehensive menopause mandate, even if the FDA has not approved testosterone therapy for the treatment of menopause symptoms.

While four other states have passed insurance mandates requiring coverage for menopause treatment or access to larger quantities of hormonal replacement therapy, no other state has enacted a law to explicitly designate testosterone therapy as a treatment for any symptom or condition associated with menopause. As a result, no other state has produced a fiscal analysis or financial impact statement to provide insight into the estimated cost to the state of enacting such legislation.

Some monthly out-of-pocket cost estimates for women paying for testosterone therapy do exist. One estimate put the monthly expense for a testosterone topical cream or gel at "$30 to $80, depending on the concentration and the pharmacy."[xlix] Another estimate indicated, "Compounded testosterone is almost never covered by insurance, and most women pay about $45 to $90 per month, depending on the formula…."[l]

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. ((P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170). The state must then defray the cost of the additional mandates by making the appropriate payment directly to an enrollee or to the insurer on the

enrollee's behalf (45 CFR 155.170). As part of the HHS Notice of Benefit and Payment Parameters for 2027, for plan years beginning on or after January 1, 2028, CMS is proposing revisions so that any State-required benefit will be considered "in addition to EHB" if "it is: 1) required by a State action taking place after December 31, 2011; 2) applicable to the small group and/or individual markets; 3) specific to required care, treatment, or services"; and 4) not necessary in order for the State to be in compliance with Federal requirements.[li] As a result of this policy revision, "states will be required to defray the cost of these additional benefits for enrollees…regardless of whether the benefit is embedded in the state's EHB-benchmark plan."[lii] This policy revision is explicitly intended to clarify that "the costs of state-required benefits in addition to EHB are defrayed by states."[liii]

Thus, although the federal defrayment rules require a state-by-state analysis and no such analysis has been performed for New Jersey, to the extent that A4642 represents a new or expanded health insurance benefit mandate, the bill's coverage mandate for testosterone therapy may trigger federal defrayment requirements. The actual effects of A4642, if it were signed into law, will depend on the extent to which it requires coverage that is not already provided by commercial insurance under the "New Jersey Menopause Coverage Act."

CONCLUSION

The "New Jersey Menopause Coverage Act" requires health insurance coverage of the expenses incurred in obtaining medically necessary perimenopause and menopause treatments. These treatments include hormonal and non-hormonal treatments, behavioral health services, pelvic floor physical therapy, bone health treatments, preventive services for early detection and treatment of health conditions related to perimenopause and menopause, such as cardiovascular disease, osteoporosis, and cancer, and counseling and education regarding menopause management. A4642 seeks to clarify that testosterone therapy is a covered treatment under that law.

Testosterone therapy has been proven to be an effective and safe treatment for HSDD, one of the symptoms or conditions associated with menopause, using male-designed hormonal methods in off-label ways. Other than for treating HSDD, there is no clinical evidence to support using testosterone therapy to treat other symptoms or conditions associated with menopause.

While four other states have enacted insurance coverage mandates for menopause or for hormonal drug products, none has explicitly included testosterone therapy for the treatment of menopause symptoms. Louisiana's menopause coverage mandate eliminates prior authorization and step therapy for any medication prescribed for hormone replacement therapy, as A4642 does with testosterone therapy. A4642 requires coverage for testosterone therapy even if it is not an FDA-approved menopause treatment.

Enacting A4642 would eliminate utilization management for testosterone therapy for the treatment of menopause symptoms. This means that carriers would have to cover testosterone therapy even if the FDA has not approved it for the treatment of a particular menopause symptom or if there is no definitive clinical evidence proving its effectiveness. This could result in testosterone therapy being prescribed for the treatment of menopause symptoms or conditions beyond the treatment of HSDD, although the lack of evidence that testosterone is effective in treating any other symptom of menopause makes this result less likely. The commission was unable to identify any fiscal estimates reviewing the potential cost of a coverage mandate for testosterone therapy, although there are estimates that have identified a potential price range for the therapy. Accordingly, it is difficult to estimate the potential cost impact of enacting A4642; a coverage mandate may increase use of testosterone therapy to treat the symptoms of menopause, which could potentially increase costs to carriers for providing coverage, which would be reflected in increased premiums for consumers. On the other hand, to the extent some carriers may already provide coverage for testosterone therapy, those carriers may not see an increase in utilization. Furthermore, to the extent that testosterone therapy may indirectly help alleviate other symptoms of menopause, such as anxiety or depression, carriers may experience lower costs in covering treatments for those attendant conditions. In any case, it is not possible to determine the cost effects of a coverage mandate for testosterone therapy or predict how utilization rates may be affected.

It is important to note that the Global Consensus Position Statement on the Use of Testosterone Therapy for Women listed, among its conclusions, that "There is an unmet need for the provision and approval of testosterone treatments specific to women, formulated with the aim of approximating physiological testosterone concentrations for premenopausal women…."[liv]

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Appendix I

ASSEMBLY, No. 4642

STATE OF NEW JERSEY

222nd LEGISLATURE

INTRODUCED MARCH 10, 2026

Sponsored by:
Assemblywoman HEATHER SIMMONS
District 3 (Cumberland, Gloucester and Salem)
Assemblywoman ROSAURA "ROSY" BAGOLIE
District 27 (Essex and Passaic)

SYNOPSIS

Clarifies that testosterone therapy is covered treatment under the "New Jersey Menopause Coverage Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 3/16/2026)

AN ACT concerning health insurance coverage of perimenopause and menopause services and amending various parts of the statutory law.

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

1. Section 1 of P.L.2025, c.200 (C.17:48-6bbb) is amended to read as follows:

1. a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage perimenopause and menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a hospital service corporation if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. A hospital service corporation shall provide clear and accessible information to subscribers or covered persons regarding covered perimenopause and menopause treatments.

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

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

Matter underlined thus is new matter.

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

[e.] f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.1)

2. Section 2 of P.L.2025, c.200 (C.17:48A-7yy) is amended to read as follows:

2. a. Every medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy [and], bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage perimenopause and menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a medical service corporation if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. A medical service corporation shall provide clear and accessible information to subscribers or covered persons regarding covered perimenopause and menopause treatments.

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

[d.**]** e. The provisions of this section shall apply to all medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.2)

3. Section 3 of P.L.2025, c.200 (C.17:48E-35.52) is amended to read as follows:

3. a. Every health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage perimenopause and menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a health service corporation if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. A health service corporation shall provide clear and accessible information to subscribers or covered persons regarding covered perimenopause and menopause treatments.

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

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

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.3)

4. Section 4 of P.L.2025, c.200 (C.17B:26-2.1uu) is amended to read as follows:

4. a. Every individual policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S. 17B: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 P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any named insured or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage perimenopause and menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by an individual policy if the prescribed therapy

is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. Every individual policy shall provide clear and accessible information to insureds regarding covered perimenopause and menopause treatments.

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

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

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.4)

5. Section 5 of P.L.2025, c.200 (C.17B:27-46.1aaa) is amended to read as follows:

5. a. Every group health policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S.17B:27-26 et seq., or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any named insured or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage perimenopause and menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a group policy if the prescribed therapy is not

indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. Every group policy shall provide clear and accessible information to insureds regarding covered perimenopause and menopause treatments.

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

[d.**]** e. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.5)

6. Section 6 of P.L.2025, c.200 (C.26:2J-4.53) is amended to read as follows:

6. a. Every enrollee agreement that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any enrollee or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a health maintenance organization if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. A health maintenance organization shall provide clear and accessible information to enrollees regarding covered perimenopause and menopause treatments.

[c.**]** d. The benefits shall be provided to the same extent as for any other medical condition under the enrollee agreement.

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

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.6)

7. Section 7 of P.L.2025, c.200 (C.17B:27A-7.36) is amended to read as follows:

7. a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by an individual health benefits plan if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. An individual health benefits plan shall provide clear and accessible information to a covered person regarding covered perimenopause and menopause treatments.

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

[d.**]** e. The provisions of this section shall apply to all enrollee agreements in which the insurer has reserved the right to change the premium.

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.7)

8. Section 8 of P.L.2025, c.200 (C. 17B:27A-19.40) is amended to read as follows:

8. a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a small employer health benefits plan if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. A small employer health benefits plan shall provide clear and accessible information to a covered person regarding covered perimenopause and menopause treatments.

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

[d.**]** e. The provisions of this section shall apply to all enrollee agreements in which the insurer has reserved the right to change the premium.

[e.**]** f. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.8)

9. Section 9 of P.L.2025, c.200 (C.52:14-17.29pp) is amended to read as follows:

9. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), that provides hospital or medical expense benefits, shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a contract purchased by the State Health Benefits Commission if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. The State Health Benefits Commission shall ensure that each contract shall provide clear and accessible information to a covered person regarding covered perimenopause and menopause treatments.

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

[d.**]** e. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.9)

10. Section 10 of P.L.2025, c.200 (C.52:14-17.46.6x) is amended to read as follows:

10. a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L.2025, c.200 (C.17:48-6bbb et al.), that provides hospital or medical expense benefits, shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy **[**and**]**, bioidentical hormone treatments, and testosterone therapy;

(2) non-hormonal treatments, including medications to manage menopausal symptoms;

(3) behavioral health care services;

(4) pelvic floor physical therapy;

(5) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(6) preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(7) counseling and education regarding menopause management.

b. Benefits for testosterone therapy, prescribed pursuant to paragraph (1) of subsection a. of this section, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied by a contract purchased by the School Employees' Health Benefits Commission if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

c. The School Employees' Health Benefits Commission shall ensure that each contract shall provide clear and accessible information to a covered person regarding covered perimenopause and menopause treatments.

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

d. As used in this section:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

(cf: P.L.2025, c.200, s.10)

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

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

(1) Inpatient hospital services

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

(6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

(11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age 22 if they are receiving such services immediately before attaining age 21;

(12) Other diagnostic, screening, preventative, and rehabilitative services, and other remedial care;

(13) Inpatient hospital services, nursing facility services, and immediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(14) Intermediate care facility services;

(15) Transportation services;

(16) Services in connection with the inpatient or outpatient treatment or care of substance use disorder, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and substance use disorder treatment center approved by the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et. seq.) and whose staff includes a medical director, and limited those services eligible for federal financial participation under Title XIX of the federal Social Security Act;

(17) Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of the federal Department of Health and Human Services, and approved by the commissioner;

(18) Comprehensive maternity care, which may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach, and follow-up services; treatment of conditions which may complicate pregnancy doula care; and physician or certified nurse midwife delivery services. For the purposes of this paragraph, "doula" means a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth, to help her to achieve the healthiest, most satisfying experience possible;

(19) Comprehensive pediatric care, which may include: ambulatory, preventive, and primary care health services. The preventive services shall include, at a minimum, the basic number of preventive visits recommended by the American Academy of Pediatrics;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice services

shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

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

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

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

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

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

(b) Expenses for medical nutrition therapy as an effective component of the person's overall treatment plan upon a: diagnosis of diabetes, gestational diabetes, or pre-diabetes; change in the beneficiary's medical condition, treatment, or diagnosis; or determination of a physician, advanced practice nurse, or physician assistant that reeducation or refresher education is necessary. Medical nutrition therapy shall be provided by an in-State provider who is a dietitian registered by a nationally-recognized professional association of dietitians, or a nutritionist holding a certified nutritionist specialist (CNS) credential from the Board for Certification of Nutrition Specialists, who is familiar with the components of diabetes medical nutrition therapy;

(c) For a person diagnosed with pre-diabetes, items and services furnished under an in-State diabetes prevention program that meets the

standards of the National Diabetes Prevention Program, as established by the federal Centers for Disease Control and Prevention; and

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

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

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

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

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

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

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

(24) Expenses incurred for the provision of pasteurized donated human breast milk, which shall include human milk fortifiers if indicated in a medical order provided by a licensed medical practitioner, to an infant under the age of six months; provided that the milk is obtained from a human milk bank that meets quality guidelines established by the Department of Health and a licensed medical practitioner has issued a medical order for the infant under at least one of the following circumstances:

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

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

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

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

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

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

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

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

(c) Prior authorization requirements shall not be imposed on any tobacco cessation services provided pursuant to this paragraph except in the following circumstances where prior authorization may be required: for a treatment that exceeds the duration recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use and dependence; or for services associated with more than two attempts to quit within a 12-month period;

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

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

(27) (a) Within 24 months of the effective date of P.L.2023, c.187 (C.30:4D-6u et al.), and conditional on the receipt of all necessary federal approvals and the securing of federal financial participation pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u), community-based palliative care benefits which shall include, but not be limited to, all of the following:

(i) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;

(ii) relief of symptoms, pain, and stress of serious illness;

(iii) improvement of quality of life for both the beneficiary and the beneficiary's family; and

(iv) appropriate care for any age and for any stage of serious illness, along with curative treatment.

(b) Benefits provided under this paragraph shall include, but shall not be limited to, services provided by a hospice pursuant to paragraph (20) of subsection b. of this section, provided that:

(i) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;

(ii) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and

(iii) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided under this paragraph.

(c) Providers authorized to deliver benefits provided under this paragraph shall include Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies licensed to provide hospice care, and other Medicaid-approved licensed health care providers.

(d) Nothing in this paragraph shall be construed to result in the elimination or reduction of covered benefits or services under the Medicaid program.

(e) This paragraph shall not affect a beneficiary's eligibility to receive, concurrently with services provided for in this paragraph, any services, including home health services, for which the beneficiary would have been eligible in the absence of this paragraph, to the extent that services are not duplicative; and

(28) (a) medically necessary treatment for women with a diagnosis of perimenopause, menopause, and symptoms associated with perimenopause and menopause, including but not limited to:

(i) hormonal therapies such as hormone replacement therapy [and], bioidentical hormone treatments, and testosterone therapy;

(ii) non-hormonal treatments, including medications to manage menopausal symptoms;

(iii)behavioral health care services;

(iv)pelvic floor physical therapy;

(v) bone health treatments, including screenings and medications due to hormonal changes related to perimenopause and menopause;

(vi)preventative services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force for early detection and treatment of health conditions related to perimenopause and menopause such as osteoporosis and cancer; and

(vii) counseling and education regarding menopause management.

(b) Benefits for testosterone therapy, prescribed pursuant to sub-subparagraph (i) of subparagraph (a) of this paragraph, shall be provided to the same extent as for any hormonal treatment under this section and shall not be denied if the prescribed therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

(c) Individuals receiving medical assistance shall be provided with clear and accessible information regarding covered perimenopause and menopause related treatments.

[(c)**]** (d) As used in this paragraph:

"Menopause" means the permanent end of a female's menstrual cycle, diagnosed by a licensed medical provider after 12 consecutive months without a menstrual period.

"Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in menstrual cycles.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Dependent children shall be provided with services cited in subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),

(4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

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

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

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

i. In the case of a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical assistance provided under this act shall be the payment of premiums for Medicare part B under 42 U.S.C. s.1395r as provided for in 42 U.S.C. s.1396d(p)(3)(A)(ii).

j. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(aa), the only medical assistance provided under this act shall be payment for authorized services provided during the period in which the

individual requires treatment for breast or cervical cancer, in accordance with criteria established by the commissioner.

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

(cf: P.L.2025, c.200, s.11)

12. This act shall take effect on the 90th day next following the date of enactment and shall apply to policies and contracts that are delivered, issued, executed or renewed on or after that date, except that policies and contracts that are delivered, issued executed, or renewed pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall be effective on January 1, 2027.

STATEMENT

This bill clarifies that testosterone therapy is a covered treatment under the "New Jersey Menopause Coverage Act."

Under the bill, health insurance carriers (including insurance companies, hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations authorized to issue health benefits plans in New Jersey, entities contracted to administer health benefits in connection with the State Health Benefits Program and School Employees' Health Benefits Program, and the New Jersey FamilyCare Program) will be required to cover, as part of their coverage of medically necessary perimenopause and menopause treatments under the "New Jersey Menopause Coverage Act," testosterone therapy. The bill also requires that benefits for the prescribed testosterone therapy be provided to the same extent as for any other hormonal treatment under the bill, and stipulates that prescribed testosterone therapy will not be denied by a carrier if the therapy is not indicated by the federal Food and Drug Administration to be approved for perimenopause or menopause.

Appendix II

NEW JERSEY GENERAL ASSEMBLY

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Roy Freiman
Assemblyman
16th District

Committees
Chair, Financial Institutions and Insurance
Vice Chair, Oversight, Reform and Federal Relations
Budget

August 27, 2026

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 A4642, which clarifies that testosterone therapy is a covered treatment under the "New Jersey Menopause Coverage Act."

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

Sadie Novak
Policy Analyst
Senate Majority Office