A STUDY OF NEW JERSEY SENATE BILL 4148

ESTABLISHES "NEW JERSEY MENOPAUSE COVERAGE ACT", REQUIRES HEALTH INSURANCE COVERAGE OF MEDICALLY NECESSARY PERIMENOPAUSE AND MENOPAUSE TREATMENTS

Report to the New Jersey Senate

November 7, 2025

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review S4148 (see Appendix I for a copy of the legislation), a bill that establishes the "New Jersey Menopause Coverage Act" and requires health insurance coverage of medically necessary perimenopause and menopause treatments. 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 State Medicaid program.[*]

S4148 would require coverage "for expenses incurred in obtaining medically necessary treatment for perimenopause, menopause, and symptoms associated with perimenopause and menopause…." Treatment would 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 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

[*] 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.

include information from a number of reputable sources that it found credible but recognizes that opinions and analyses may differ.

MEDICAL EVIDENCE

The National Institute of Aging defines menopause as "the stages of a woman's life when her menstrual periods stop permanently, and she can no longer get pregnant."[i] More specifically, menopause is caused by a decline in the body's production of the reproductive hormones, estrogen and progesterone, that cause menstruation.[ii,iii] The body's transition into menopause can be classified into three stages: perimenopause, menopause, and postmenopause. Perimenopause is the transition phase into menopause, menopause is defined 12 months without menstruation, and postmenopause describes the stage, lasting until the end of life, after the transition into menopause is complete. Generally, the menopausal transition takes place between the ages of 45 and 55, with 52 being the average age of menopause in the United States.[iv]

Certain risk factors that increase one's chances of beginning the menopause transition earlier in life, including:

- Smoking tobacco
- Having a hysterectomy or oophorectomy (removal of ovaries)
- Family history of early menopause
- Autoimmune disorders
- Received treatments for cancer (chemotherapy, radiation, medication).[v]

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.[vi] The Mayo Clinic notes other symptoms can include irregular periods and vaginal dryness.[vii] The intensity of these symptoms differs from person to person, and some people may not experience any symptoms at all.

Individuals undergoing menopause are at increased risk of developing certain health conditions, such as osteoporosis, heart disease, and stroke, resulting from the body's lack of estrogen production. Specifically,

- **Osteoporosis:** Estrogen strengthens bone mass, so as estrogen drops, bones become more fragile and prone to breakage.
- **Heart disease:** Estrogen helps keep heart arteries (blood vessels) open and supports healthy blood flow. As estrogen decreases, the risk of higher levels of low-density lipoprotein (LDL) cholesterol (also known as "bad" cholesterol) rises. As a result, the risk of heart disease also increases.

- **Stroke:** Similar to the increased risk of heart disease, estrogen's effect on blood vessels can also affect the brain. As blood vessels work with less estrogen, they can constrict and increase the risk of stroke.[viii]

The earlier a person starts to experience menopause, the higher the risk the person will develop one of these major health conditions, each of which can result in adverse or debilitating health outcomes. For example, osteoporosis puts one at a "higher lifetime risk of bone fracture."[ix] Although it is not possible to fully prevent the symptoms or potential health risks associated with menopause, there are treatment options available that can help alleviate symptoms and reduce long-term health concerns.

Hormone Replacement Therapy (HRT), which is used to replenish estrogen levels in the body, is a commonly recommended treatment for menopause.[x] HRT comes in two main forms: systemic therapy, which is absorbed by the whole body; and low-dose vaginal estrogen, which is a localized treatment under which estrogen is applied directly inside the vagina. Forms of systemic HRT, which is intended to alleviate the broader symptoms of menopause, include pills, skin patches, rings, creams, sprays, and gels.[xi] In contrast, low-dose vaginal estrogen is designed to alleviate certain symptoms of menopause that occur in the vagina, including dryness, irritation, discharge, frequent urination, increased susceptibility to urinary tract infections, and discomfort or pain during sexual intercourse.[xii] As the name suggests, low-dose vaginal estrogen is a less-potent form of treatment than systemic HRT. In some cases, patients are prescribed a combination of systemic HRT and low-dose vaginal estrogen, particularly when systemic HRT does not fully resolve the vaginal symptoms of menopause.[xiii]

Evidence from randomized controlled trials and large observational studies suggests that HRT is very effective when given to women during perimenopause and can reduce overall mortality rates and the incidence of cardiovascular disease.[xiv] These studies have led experts to conclude that HRT not only aids in relieving the symptoms of menopause but also lowers the risk of health issues later in life.

However, HRT may not be the right treatment for everyone. For some, HRT is not a safe option due to previous health issues like estrogen-dependent cancer, in which cases experts recommend treatment using anti-depressants to treat severe mood symptoms and gabapentin to treat symptoms like hot flashes and problems sleeping.[xv] The Memorial Solan Kettering Cancer Center further recommends increasing vitamin D and calcium intake, reducing smoking, and maintaining a balanced diet.[xvi] Although it has been suggested that other supplements, like red clover and soy, may help reduce or alleviate the symptoms of menopause, studies examining the efficacy of these supplements in treating menopause symptoms are inconclusive.[xvii]

Other forms of treatment for perimenopause and menopause incorporate pelvic floor physical therapy and bone health treatments. Pelvic floor physical therapy strengthens the pelvic floor muscles to combat weakness and loss of elasticity, improving bladder control, reducing pelvic

pain, and enhancing sexual function.[xviii] For bone health treatments, bisphosphonates, such as alendronate, risedronate, ibandronate, and zoledronic acid, are recommended for someone experiencing osteoporosis. Alternatively, denosumab may be an option when bisphosphonates are contraindicated.[xix]

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.[xx] 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."[xxi]

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.[xxii] 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, which 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.[xxiii] 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.[xxiv]

Studies have also identified racial disparities in clinical outcomes for postmenopausal women, including racial disparities in the prevalence and outcomes of major fragility fractures. One study noted that osteoporosis is less common among Black women; however, Black women who develop osteoporosis have "significantly worse clinical outcomes after hip and several other types of fragility fractures."[xxv] Black women with postmenopausal osteoporosis (PMO), are more likely to experience mortality and debility one year after fracture compared to White women, and may be significantly vulnerable to adverse financial effects resulting from such injuries.[xxvi]

OTHER STATES

Two states, Louisiana and Illinois, have enacted laws mandating insurance coverage for the treatment of menopause, while one other state, California, recently reintroduced such legislation after it was vetoed in the last legislative session.

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, HB392 of 2024, which became Act No. 784 of 2024, covers both perimenopausal and menopausal care, provides for hormonal and symptomatic treatment, and extends such care to health insurance issuers and Medicaid enrollees.

Louisiana's law requires insurance coverage "for any medically necessary care or treatment for menopause and perimenopause." Act No. 784 also eliminates "prior authorization, step-therapy or fail-first policy or protocol for…any medication administered or prescribed for hormone replacement therapy used to treat symptoms of menopause and perimenopause…."[xxvii] Act No. 784 further requires coverage of inpatient and outpatient care or treatment of perimenopause or menopause, including hormonal care, for people covered under the state's Medicaid program. If a licensed healthcare provider certifies that the care is medically necessary and appropriate, enrollees are covered for treatment of perimenopausal and menopausal symptoms, including, but not limited to, irregular menstrual periods, hot flashes, vaginal or bladder problems, loss of bone, and sleep disruption, including night sweats.[xxviii]

The final version of the legislation passed the Louisiana House by a vote of 71-14 and passed the Senate by a vote of 38-0. The bill became law without the Governor's signature on June 25, 2024, and took effect on August 1, 2024.

Illinois

Illinois was the second state to enact an insurance coverage mandate for the treatment of menopause, HB5295, adopted as Public Act 103-0703 of 2024. Prior to the adoption of Public Act 103-0703, Illinois law mandated coverage for the treatment of menopause in the group and individual commercial markets, and only covered medically necessary hormonal therapy to treat menopause induced by a hysterectomy.

Public Act 103-0703 expanded commercial coverage for menopause treatment in several aspects, including 1) expanding the coverage requirement for treating menopause induced by a hysterectomy to include non-hormonal therapy in addition to the existing mandate for hormonal therapy; and 2) requiring commercial insurers to cover "medically necessary hormonal and non-hormonal therapy to treat menopausal symptoms…."[xxix] Public Act 103-0703 requires that the

therapy be recommended by a qualified health care provider and have been proven safe and effective in peer-reviewed scientific studies. 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."[xxx] Finally, Public Act 103-0703 requires Illinois' Medicaid program to cover medically necessary hormonal therapy to treat menopause induced by a hysterectomy.

Illinois' law requiring coverage for menopause treatment applies to "A group or individual policy of accident and health insurance or a managed care plan…."[xxxi] Public Act 103-0703 passed the Illinois House by a vote of 111-0 and passed the Senate by a vote of 58-0. The law was approved by the Governor on July 19, 2024, and becomes effective on January 1, 2026.

Pending Legislation Mandating Coverage for Menopause Treatment

California

California's bill mandating insurance coverage for the treatment of menopause, AB2467, was passed by both houses of the California legislature in 2024 but was vetoed by the Governor. The bill would have required health care service plan contracts and health insurance policies, except for specialized health insurance policies, to provide "coverage for evaluation and treatment options for perimenopause and menopause, as is deemed medically necessary by the treating health care provider without utilization management…."[xxxii] The bill would have excluded Medi-Cal (i.e., Medicaid) managed care plans that contract with the State Department of Health Care Services from these provisions.

Treatment options covered under the bill would have included, but not been limited to, at least one option in each formulation of, and the associated method of administration for, federal FDA-regulated systemic hormone therapy, non-hormonal medications for each menopause symptom, treatment for genitourinary syndrome of menopause, and at least one from each class of medications approved to prevent and treat osteoporosis. The bill defined "formulation" to mean a tablet or capsule, transdermal patch, topical spray, cream, gel, or lotion, or a vaginal suppository, cream, or silicone ring. "Method of administration" was defined as administering a formulation via an oral, topical, vaginal, subcutaneous, injectable, or intravenous route of administration.[xxxiii]

AB2467 passed the California Senate by a vote of 34-1-5 and passed the Assembly by a vote of 76-0-3. The bill was returned to the legislature without the signature of the Governor on September 28, 2024. California Governor Gavin Newsom cited several reasons for his decision not to sign AB2467 into law, although he indicated his primary reason was, "[T]his bill's expansive coverage mandate in conjunction with a prohibition on utilization management (UM) is too far-reaching."[xxxiv] Governor Newsom elaborated that the prohibition on UM would

eliminate the means that health plans use to ensure that insured members receive the proper care at the right time, an essential need when there are "new and emerging treatments." The Governor also asserted that mandating coverage for non-FDA approved treatments was unprecedented, and that all of these issues, combined with "ambiguities in the bill for undefined terms, raise concerns for cost containment and bill implementation."[xxxv] A nearly identical bill, AB432, was introduced in the California Assembly on February 5, 2025, but to date has not advanced in the legislative process in the current session.

DISCUSSION

As noted above, a Mayo Clinic study of the economic impacts of menopause on women in the workplace conservatively estimated lost productivity due to the symptoms of menopause at $1.8 billion per year. To put that estimate in perspective, the Mayo clinic researchers cited a Centers for Disease Control and Prevention analysis of the total cost of lost worker productivity in missed days of work as a result of all chronic diseases and lifestyle behaviors. The total loss to U.S. employers for all missed workdays from causes such as hypertension, diabetes, physical inactivity, smoking, and obesity was estimated at $36.4 billion.[xxxvi] The study's authors concluded that it is in employers' interests to address lost productivity resulting from menopausal symptoms.[xxxvii]

The Mayo Clinic researchers elaborated on additional societal benefits from "improving workplace menopause support and facilitating access to high-quality, evidence-based health care for menopause symptom management."[xxxviii] Working women in midlife are potentially entering periods of career advancement and are in a position to assume leadership roles. If menopausal symptoms cause women to forgo work advancement opportunities or leave employment altogether, workplaces lose out on the potential of more women in leadership positions and women miss opportunities for greater financial security and personal development. When women leave the workforce prematurely, they are also taking with them both industry and institutional expertise, the lost value of which may be impossible to calculate. The Mayo Clinic authors also cited research positing that working women with menopausal symptoms "have a better quality of life compared with unemployed women, suggesting that improving the work environment may offer an opportunity to further enhance quality of life for working women with menopause symptoms."[xxxix]

The substantive effects of S4148, if it were signed into law, will depend on the extent to which it requires coverage that is not already provided by commercial insurance. For example, the coverage requirements established under the federal Patient Protection and Affordable Care Act for preventive care services include coverage for preventive care for osteoporosis and cardiovascular disease, both of which conditions can develop during the menopausal transition; accordingly, coverage requirements for these and other menopausal-affiliated conditions that

would be codified under S4148 may fall within existing coverage requirements. Another consideration is that, because S4148 requires coverage "for expenses incurred in obtaining medically necessary treatment for perimenopause, menopause, and symptoms associated with perimenopause and menopause…." it will depend on determinations of medical necessity as to what "expenses" would be required to be covered.

Louisiana and Illinois have enacted laws to expand insurance coverage for the treatment of perimenopause and menopause. The Governor of California, conversely, did not sign his state's menopause coverage mandate bill into law, citing the expense of expanding coverage, the preclusion of cost containment provisions such as utilization management, and the difficulties of implementation.

FINANCIAL IMPACT

Of the three states that have passed laws or introduced legislation requiring insurance coverage for the treatment of menopause, only Louisiana and California produced financial analyses or fiscal notes that assessed the potential financial impact of the new mandates. The legislative history of Illinois HB5295 did not include a fiscal note.

Louisiana's Legislative Fiscal Office (LFO) produced a Fiscal Note on HB392. The analysis indicated that all five of the self-funded health plans in the state already provided coverage for medically necessary care for perimenopause and menopause. The fiscal note, however, did not provide an estimate of the impact on premiums of eliminating prior authorization and step therapy protocols for medications administered or prescribed for hormone replacement therapy used to treat menopause symptoms.[xl]

As for Louisiana's Medicaid program, the LFO fiscal note indicted, "There is no anticipated direct effect on Medicaid expenditures as a result of this measure."[xli] The Louisiana Department of Health pointed out that the state's Medicaid program already provides all medically necessary care to treat perimenopause, menopause, and their symptoms, including hormonal and non-hormonal treatments (subject to prior authorization), prescription medications, and preventive care and counseling. The Louisiana LFO estimated that the mandate would result in no additional expenditures by the state's Medicaid program over the next five years.[xlii]

For California, the Department of Managed Health Care (DMHC) regulates health plans, while the California Department of Insurance (CDI) regulates health policies. The California Health Benefits Review Program (CHBRP) is charged with producing analyses of the impacts of health care bills, including fiscal effects. In its review of AB2467, the CHBRP estimated that the proposed coverage mandate for perimenopause and menopause treatment would increase total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies by $3,993,000 million, or 0.0025%.[xliii]

Of the approximately $4 million in additional annual expenditures estimated by the CHBRP, $2.91 million represented increased premiums for employer sponsored insurance and health plans, $340,000 represented premium increases for coverage under the California Public Employees Retirement System (CalPERS), $672,000 represented increased premiums paid by enrollees with individual coverage, and $917,000 represented increased premiums for enrollees with group coverage.[xliv] In its analysis of AB2467, the Senate Rules Committee reported, "[T]he prohibition of utilization management and the assignment of medical necessity determination exclusively to the provider would likely create additional (higher) fiscal impacts." No estimate of the magnitude of this higher impact was provided, because the potential "set of additional drugs and additional treatments are unknown."[xlv]

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). A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state's exchange to the state. Defrayment does not apply to the large group market. For more information on State-required benefits, please refer to this CMS FAQ on Defrayal of State Additional Required Benefits.[xlvi] As part of the HHS Notice of Benefit and Payment Parameters for 2025, for plan years beginning on or after January 1, 2027, CMS is proposing revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process.[xlvii] The process of updating the state's EHB-benchmark plan could create a pathway to adding benefits to the benchmark plan that may not trigger defrayal, provided certain parameters are met. Thus, although this is a state-by-state analysis and no such analysis has been performed for New Jersey, to the extent it would represent a new or expanded health insurance benefit mandate, a coverage mandate for the treatment of perimenopause and menopause may trigger the federal defrayment requirements.

CONCLUSION

S4148 would require 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.

Louisiana and Illinois have both adopted laws to expand insurance coverage for the diagnosis and treatment of perimenopause and menopause. Louisiana extended coverage to the state's commercial markets and Medicaid program for any medically necessary care or treatment for menopause or perimenopause. Louisiana's law also eliminated prior authorization and step therapy for any medication prescribed for HRT. Illinois' law was much more limited, expanding an existing commercial coverage mandate that was limited to hormonal therapy to treat menopause induced by a hysterectomy, to additionally include medically necessary hormonal and non-hormonal therapy to treat menopause induced by a hysterectomy, and to apply this same coverage mandate to the state's Medicaid program. Illinois' law did not address insurance coverage in either the commercial market or the Medicaid program for perimenopause or menopause resulting from natural aging or other causes.

It has been shown that early diagnosis and treatment of perimenopause using HRT is associated with better health outcomes, including lower overall mortality rates and a lower incidence of cardiovascular disease in later life, as well as reducing the potential for those experiencing menopause to develop other, affiliated chronic conditions. Beyond the beneficial long-term health impacts, treatment of perimenopause and menopause symptoms can also improve the quality of life for women experiencing hot flashes, insomnia, and other symptoms. However, one study with a large sample of women in the relevant age range reported that, while 80% of the women reported having menopausal symptoms, fewer than 20% reported having received a clinical menopause diagnosis.

For employed women of middle age, menopause symptoms can present a significant barrier to career advancement. That obstacle poses costs both to the economy, in terms of lost productivity and missed workdays, and to the financial security and quality of life of women experiencing the transition to menopause. Research suggests it is in the interests of both employers and society to find better workplace accommodations and wider treatment of perimenopause and menopause symptoms. To the extent S4148 would codify or expand existing coverage, it may help promote awareness of treatment options and reduce barriers to accessing care for women experiencing perimenopause and menopause, which, in turn, may alleviate the adverse personal and societal effects of untreated and undertreated menopause.

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SENATE, No. 4148

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 25, 2025

Sponsored by:
Senator JOHN J. BURZICHELLI
District 3 (Cumberland, Gloucester and Salem)
Senator ANGELA V. MCKNIGHT
District 31 (Hudson)

Co-Sponsored by:
Senator Burgess

SYNOPSIS

Establishes “New Jersey Menopause Coverage Act”; requires health insurance coverage of medically necessary perimenopause and menopause treatments.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 3/17/2025)

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

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

1. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling regarding menopause management.

b. A hospital service corporation shall provide clear and accessible information to subscribers or covered persons 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. 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. As used in this section:

"Menopause" means the natural and 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.

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 <u>thus</u> is new matter.

2. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. A medical service corporation shall provide clear and accessible information to subscribers or covered persons 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. 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. As used in this section:

"Menopause" means the natural and 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.

3. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. A health service corporation shall provide clear and accessible information to subscribers or covered persons 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. 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. As used in this section:

"Menopause" means the natural and 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.

4. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any named insured or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

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

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

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

e. As used in this section:

"Menopause" means the natural and 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.

5. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any named insured or other person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

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

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

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

e. As used in this section:

"Menopause" means the natural and 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.

6. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any enrollee or other person covered thereunder for expenses incurred in obtaining medically necessary treatment related to perimenopause and menopause, including but not limited to:

(1) hormonal therapies such as hormone replacement therapy and bioidentical hormone treatments;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

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

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

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

e. As used in this section:

"Menopause" means the natural and 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.

7. (New section) 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. , c. (C.) (pending before the Legislature as this bill), shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. An individual health benefits plan 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 health benefits plan.

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

e. As used in this section:

"Menopause" means the natural and 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.

8. (New section) 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. , c. (C.) (pending before the Legislature

as this bill), shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. A small employer health benefits plan 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 health benefits plan.

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

e. As used in this section:

"Menopause" means the natural and 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.

9. (New section) a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), that provides hospital or medical expense benefits, shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. 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. 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 natural and 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.

10. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), that provides hospital or medical expense benefits, shall provide benefits to any person covered thereunder for expenses incurred in obtaining medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

b. 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 natural and 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.

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; **[**and**]**

(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 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(vi) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(vii) counseling and education regarding menopause management.

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

(c) As used in this paragraph:

"Menopause" means the natural and 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.2023, c.187, s.1)

12. This act shall take effect on the 90th day next following enactment and shall apply to policies and contracts that are delivered, issued, executed or renewed on or after that date.

STATEMENT

This bill establishes the "New Jersey Menopause Coverage Act" and requires health insurance coverage of medically necessary perimenopause and menopause treatments.

Under the bill, health insurance carriers (including insurance companies, hospital service corporations, medical service corporations, health service corporations, health maintenance organizations authorized to issue health benefits plans in New Jersey, entities contracted to administer health benefits in connection with the State Health Benefits Program and School Employees' Health Benefits Program, and the New Jersey FamilyCare Program) will be required to cover medically necessary treatment for 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;

(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, medications, and supplements, due to hormonal changes related to perimenopause and menopause;

(6) preventative services for early detection and treatment of health conditions related to perimenopause and menopause such as cardiovascular disease, osteoporosis, and cancer; and

(7) counseling and education regarding menopause management.

The bill also requires that carriers are to provide clear and accessible information to covered persons regarding perimenopause and menopause treatments.

For the purpose of this bill, "menopause" means the natural and 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.

Appendix II

Liza Ackerman
Jamie Galemba
Office of Legislative Services
Committee Aides
609-847-3845

NEW JERSEY LEGISLATURE

SENATE COMMERCE COMMITTEE

STATE HOUSE ANNEX · P.O. BOX 068 · TRENTON, NJ 08625-0068
www.njleg.gov

May 5, 2025

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

Dear Members of the Commission:

As the Chair of the Senate Commerce Committee, I respectfully request the Commission to review and prepare a written report of Senate Bill 4148, sponsored by Senators Burzichelli and McKnight. The bill would establish the "New Jersey Menopause Coverage Act"; requiring health insurance coverage of medically necessary perimenopause and menopause treatments.

If you have any questions, please do not hesitate to contact Allison Meyers or David Smith, Senate Commerce Committee Aides, at 609-847-3700. Thank you for your immediate attention to this matter.

Sincerely,

Joseph A. Lagana
Senator, 38th District

CC: Allison Meyers
Policy Analyst
Senate Majority Office

David Smith
Senior Policy Analyst
Senate Majority Office