

[Second Reprint]

ASSEMBLY, No. 5278

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 10, 2025

Sponsored by:

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Assemblyman ROY FREIMAN

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SYNOPSIS

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

CURRENT VERSION OF TEXT

As reported by the Assembly Financial Institutions and Insurance Committee on June 19, 2025, with amendments.

(Sponsorship Updated As Of: 12/22/2025)

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

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

7
 8 1. (New section) a. A hospital service corporation contract
 9 that provides hospital or medical expense benefits and is delivered,
 10 issued, executed or renewed in this State pursuant to P.L.1938,
 11 c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in
 12 this State by the Commissioner of Banking and Insurance on or
 13 after the effective date of P.L. , c. (C.) (pending before the
 14 Legislature as this bill), shall provide benefits to any named
 15 subscriber or other person covered thereunder for expenses incurred
 16 in obtaining medically necessary treatment for ²women with a
 17 diagnosis of² perimenopause, menopause, and symptoms associated
 18 with perimenopause and menopause, including but not limited to:

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

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

23 (3) behavioral health care services;

24 (4) pelvic floor physical therapy;

25 (5) bone health treatments, including screenings²[.] and²
 26 medications ²[, and supplements,]² due to hormonal changes
 27 related to perimenopause and menopause;

28 (6) preventative services ²that have a rating of “A” or “B” in the
 29 current recommendations of the United States Preventive Services
 30 Task Force² for early detection and treatment of health conditions
 31 related to perimenopause and menopause such as ²[cardiovascular
 32 disease,]² osteoporosis²[,]² and cancer; and

33 (7) counseling regarding menopause management.

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

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

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

42 e. As used in this section:

43 “Menopause” means the ¹[natural and]¹ permanent end of a
 44 female’s menstrual cycle, diagnosed by a licensed medical provider
 45 after 12 consecutive months without a menstrual period.

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.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AHE committee amendments adopted March 20, 2025.

²Assembly AFI committee amendments adopted June 19, 2025.

1 “Perimenopause” means the transitional period leading to
2 menopause, marked by fluctuating hormone levels and changes in
3 menstrual cycles.

4
5 2. (New section) a. Every medical service corporation
6 contract that provides hospital or medical expense benefits and is
7 delivered, issued, executed or renewed in this State pursuant to
8 P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
9 renewal in this State by the Commissioner of Banking and
10 Insurance on or after the effective date of P.L. , c. (C.)
11 (pending before the Legislature as this bill), shall provide benefits
12 to any named subscriber or other person covered thereunder for
13 expenses incurred in obtaining medically necessary treatment for
14 ²women with a diagnosis of² perimenopause, menopause, and
15 symptoms associated with perimenopause and menopause,
16 including but not limited to:

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

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

21 (3) behavioral health care services;

22 (4) pelvic floor physical therapy;

23 (5) bone health treatments, including screenings²[.] and²
24 medications ²[, and supplements,]² due to hormonal changes
25 related to perimenopause and menopause;

26 (6) preventative services ²that have a rating of “A” or “B” in the
27 current recommendations of the United States Preventive Services
28 Task Force² for early detection and treatment of health conditions
29 related to perimenopause and menopause such as ²[cardiovascular
30 disease,]² osteoporosis²[,]² and cancer; and

31 (7) counseling and education regarding menopause
32 management.

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

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

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

41 e. As used in this section:

42 “Menopause” means the ¹[natural and]¹ permanent end of a
43 female’s menstrual cycle, diagnosed by a licensed medical provider
44 after 12 consecutive months without a menstrual period.

45 “Perimenopause” means the transitional period leading to
46 menopause, marked by fluctuating hormone levels and changes in
47 menstrual cycles.

1 3. (New section) a. Every health service corporation contract
2 that provides hospital or medical expense benefits and is delivered,
3 issued, executed or renewed in this State pursuant to P.L.1985,
4 c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in
5 this State by the Commissioner of Banking and Insurance on or
6 after the effective date of P.L. , c. (C.) (pending before the
7 Legislature as this bill), shall provide benefits to any named
8 subscriber or other person covered thereunder for expenses incurred
9 in obtaining medically necessary treatment for ²women with a
10 diagnosis of² perimenopause, menopause, and symptoms associated
11 with perimenopause and menopause, including but not limited to:

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

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

16 (3) behavioral health care services;

17 (4) pelvic floor physical therapy;

18 (5) bone health treatments, including screenings²[,] and²
19 medications ²[,] and supplements,²]² due to hormonal changes
20 related to perimenopause and menopause;

21 (6) preventative services ²that have a rating of “A” or “B” in the
22 current recommendations of the United States Preventive Services
23 Task Force² for early detection and treatment of health conditions
24 related to perimenopause and menopause such as ²[cardiovascular
25 disease,]² osteoporosis²[,]² and cancer; and

26 (7) counseling and education regarding menopause
27 management.

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

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

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

36 e. As used in this section:

37 “Menopause” means the ¹[natural and]¹ permanent end of a
38 female’s menstrual cycle, diagnosed by a licensed medical provider
39 after 12 consecutive months without a menstrual period.

40 “Perimenopause” means the transitional period leading to
41 menopause, marked by fluctuating hormone levels and changes in
42 menstrual cycles.

43

44 4. (New section) a. Every individual policy that provides
45 hospital or medical expense benefits and is delivered, issued,
46 executed or renewed in this State pursuant to N.J.S. 17B:26-1 et
47 seq., or approved for issuance or renewal in this State by the
48 Commissioner of Banking and Insurance on or after the effective

1 date of P.L. , c. (C.) (pending before the Legislature as this
2 bill), shall provide benefits to any named insured or other person
3 covered thereunder for expenses incurred in obtaining medically
4 necessary treatment for ²women with a diagnosis of²
5 perimenopause, menopause, and symptoms associated with
6 perimenopause and menopause, including but not limited to:
7 (1) hormonal therapies such as hormone replacement therapy
8 and bioidentical hormone treatments;
9 (2) non-hormonal treatments, including medications to manage
10 perimenopause and menopausal symptoms;
11 (3) behavioral health care services;
12 (4) pelvic floor physical therapy;
13 (5) bone health treatments, including screenings²[,] and²
14 medications ²[, and supplements,]² due to hormonal changes
15 related to perimenopause and menopause;
16 (6) preventative services ²that have a rating of “A” or “B” in the
17 current recommendations of the United States Preventive Services
18 Task Force² for early detection and treatment of health conditions
19 related to perimenopause and menopause such as ²[cardiovascular
20 disease,]² osteoporosis²[,]² and cancer; and
21 (7) counseling and education regarding menopause
22 management.
23 b. Every individual policy shall provide clear and accessible
24 information to insureds regarding covered perimenopause and
25 menopause treatments.
26 c. The benefits shall be provided to the same extent as for any
27 other medical condition under the policy.
28 d. The provisions of this section shall apply to all health
29 insurance policies in which the insurer has reserved the right to
30 change the premium.
31 e. As used in this section:
32 “Menopause” means the ¹[natural and]¹ permanent end of a
33 female’s menstrual cycle, diagnosed by a licensed medical provider
34 after 12 consecutive months without a menstrual period.
35 “Perimenopause” means the transitional period leading to
36 menopause, marked by fluctuating hormone levels and changes in
37 menstrual cycles.
38
39 5. (New section) a. Every group health policy that provides
40 hospital or medical expense benefits and is delivered, issued, executed
41 or renewed in this State pursuant to N.J.S.17B:27-26 et seq., or
42 approved for issuance or renewal in this State by the Commissioner of
43 Banking and Insurance on or after the effective date of
44 P.L. , c. (C.) (pending before the Legislature as this bill), shall
45 provide benefits to any named insured or other person covered
46 thereunder for expenses incurred in obtaining medically necessary
47 treatment for ²women with a diagnosis of² perimenopause,

1 menopause, and symptoms associated with perimenopause and
2 menopause, including but not limited to:

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

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

7 (3) behavioral health care services;

8 (4) pelvic floor physical therapy;

9 (5) bone health treatments, including screenings² and²
10 medications², and supplements,² due to hormonal changes related
11 to perimenopause and menopause;

12 (6) preventative services² that have a rating of “A” or “B” in the
13 current recommendations of the United States Preventive Services
14 Task Force² for early detection and treatment of health conditions
15 related to perimenopause and menopause such as ²cardiovascular
16 disease,² osteoporosis², and cancer; and

17 (7) counseling and education regarding menopause management.

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

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

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

25 e. As used in this section:

26 “Menopause” means the ¹natural and¹ permanent end of a
27 female’s menstrual cycle, diagnosed by a licensed medical provider
28 after 12 consecutive months without a menstrual period.

29 “Perimenopause” means the transitional period leading to
30 menopause, marked by fluctuating hormone levels and changes in
31 menstrual cycles.

32

33 6. (New section) a. Every enrollee agreement that provides
34 hospital or medical expense benefits and is delivered, issued, executed
35 or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et
36 seq.), or approved for issuance or renewal in this State by the
37 Commissioner of Banking and Insurance on or after the effective date
38 of P.L. , c. (C.) (pending before the Legislature as this bill),
39 shall provide benefits to any enrollee or other person covered
40 thereunder for expenses incurred in obtaining medically necessary
41 treatment ²related to for women with a diagnosis of² perimenopause
42 and menopause, including but not limited to:

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

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

47 (3) behavioral health care services;

48 (4) pelvic floor physical therapy;

1 (5) bone health treatments, including screenings²[.] and²
2 medications ²[, and supplements,]² due to hormonal changes related
3 to perimenopause and menopause;

4 (6) preventative services ²that have a rating of “A” or “B” in the
5 current recommendations of the United States Preventive Services
6 Task Force² for early detection and treatment of health conditions
7 related to perimenopause and menopause such as ²[cardiovascular
8 disease,]² osteoporosis²[,]² and cancer; and

9 (7) counseling and education regarding menopause management.

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

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

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

18 e. As used in this section:

19 “Menopause” means the ¹[natural and]¹ permanent end of a
20 female’s menstrual cycle, diagnosed by a licensed medical provider
21 after 12 consecutive months without a menstrual period.

22 “Perimenopause” means the transitional period leading to
23 menopause, marked by fluctuating hormone levels and changes in
24 menstrual cycles.

25
26 7. (New section) a. Every individual health benefits plan that
27 provides hospital or medical expense benefits and is delivered, issued,
28 executed or renewed in this State pursuant to P.L.1992, c.161
29 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this
30 State by the Commissioner of Banking and Insurance on or after the
31 effective date of P.L. , c. (C.) (pending before the Legislature
32 as this bill), shall provide benefits to any person covered thereunder
33 for expenses incurred in obtaining medically necessary treatment for
34 ²women with a diagnosis of² perimenopause, menopause, and
35 symptoms associated with perimenopause and menopause, including
36 but not limited to:

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

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

41 (3) behavioral health care services;

42 (4) pelvic floor physical therapy;

43 (5) bone health treatments, including screenings²[.] and²
44 medications ²[, and supplements,]² due to hormonal changes related
45 to perimenopause and menopause;

46 (6) preventative services ²that have a rating of “A” or “B” in the
47 current recommendations of the United States Preventive Services
48 Task Force² for early detection and treatment of health conditions

1 related to perimenopause and menopause such as ²[cardiovascular
2 disease,²] osteoporosis²[,²] and cancer; and

3 (7) counseling and education regarding menopause management.

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

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

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

12 e. As used in this section:

13 “Menopause” means the ¹[natural and]¹ permanent end of a
14 female’s menstrual cycle, diagnosed by a licensed medical provider
15 after 12 consecutive months without a menstrual period.

16 “Perimenopause” means the transitional period leading to
17 menopause, marked by fluctuating hormone levels and changes in
18 menstrual cycles.

19

20 8. (New section) a. Every small employer health benefits plan
21 that provides hospital or medical expense benefits and is delivered,
22 issued, executed or renewed in this State pursuant to P.L.1992, c.162
23 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this
24 State by the Commissioner of Banking and Insurance on or after the
25 effective date of P.L. , c. (C.) (pending before the Legislature
26 as this bill), shall provide benefits to any person covered thereunder
27 for expenses incurred in obtaining medically necessary treatment for
28 ²women with a diagnosis of² perimenopause, menopause, and
29 symptoms associated with perimenopause and menopause, including
30 but not limited to:

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

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

35 (3) behavioral health care services;

36 (4) pelvic floor physical therapy;

37 (5) bone health treatments, including screenings²[,²] and²
38 medications ²[, and supplements,²] due to hormonal changes related
39 to perimenopause and menopause;

40 (6) preventative services ²that have a rating of “A” or “B” in the
41 current recommendations of the United States Preventive Services
42 Task Force² for early detection and treatment of health conditions
43 related to perimenopause and menopause such as ²[cardiovascular
44 disease,²] osteoporosis²[,²] and cancer; and

45 (7) counseling and education regarding menopause management.

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

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

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

6 e. As used in this section:

7 “Menopause” means the ¹[natural and]¹ permanent end of a
8 female’s menstrual cycle, diagnosed by a licensed medical provider
9 after 12 consecutive months without a menstrual period.

10 “Perimenopause” means the transitional period leading to
11 menopause, marked by fluctuating hormone levels and changes in
12 menstrual cycles.

13

14 9. (New section) a. The State Health Benefits Commission shall
15 ensure that every contract purchased by the commission on or after the
16 effective date of P.L. , c. (C.) (pending before the Legislature
17 as this bill), that provides hospital or medical expense benefits, shall
18 provide benefits to any person covered thereunder for expenses
19 incurred in obtaining medically necessary treatment for ²women with a
20 diagnosis of² perimenopause, menopause, and symptoms associated
21 with perimenopause and menopause, including but not limited to:

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

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

26 (3) behavioral health care services;

27 (4) pelvic floor physical therapy;

28 (5) bone health treatments, including screenings²[.] and²
29 medications ²[, and supplements,]² due to hormonal changes related
30 to perimenopause and menopause;

31 (6) preventative services ²that have a rating of “A” or “B” in the
32 current recommendations of the United States Preventive Services
33 Task Force² for early detection and treatment of health conditions
34 related to perimenopause and menopause such as ²[cardiovascular
35 disease,]² osteoporosis²[,]² and cancer; and

36 (7) counseling and education regarding menopause management.

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

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

42 d. As used in this section:

43 “Menopause” means the ¹[natural and]¹ permanent end of a
44 female’s menstrual cycle, diagnosed by a licensed medical provider
45 after 12 consecutive months without a menstrual period.

46 “Perimenopause” means the transitional period leading to
47 menopause, marked by fluctuating hormone levels and changes in
48 menstrual cycles.

1

2 10. (New section) a. The School Employees' Health Benefits
3 Commission shall ensure that every contract purchased by the
4 commission on or after the effective date of P.L. , c. (C.)
5 (pending before the Legislature as this bill), that provides hospital or
6 medical expense benefits, shall provide benefits to any person covered
7 thereunder for expenses incurred in obtaining medically necessary
8 treatment for ²women with a diagnosis of² perimenopause,
9 menopause, and symptoms associated with perimenopause and
10 menopause, including but not limited to:

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

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

15 (3) behavioral health care services;

16 (4) pelvic floor physical therapy;

17 (5) bone health treatments, including screenings²[.] and²
18 medications ²[, and supplements,²] due to hormonal changes related
19 to perimenopause and menopause;

20 (6) preventative services ²that have a rating of "A" or "B" in the
21 current recommendations of the United States Preventive Services
22 Task Force² for early detection and treatment of health conditions
23 related to perimenopause and menopause such as ²[cardiovascular
24 disease,²] osteoporosis²[,]² and cancer; and

25 (7) counseling and education regarding menopause management.

26 b. The School Employees Health Benefits Commission shall
27 ensure that each contract shall provide clear and accessible
28 information to a covered person regarding covered perimenopause and
29 menopause treatments.

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

32 d. As used in this section:

33 "Menopause" means the ¹[natural and]¹ permanent end of a
34 female's menstrual cycle, diagnosed by a licensed medical provider
35 after 12 consecutive months without a menstrual period.

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

39

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

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

47 (1) Inpatient hospital services

48 (2) Outpatient hospital services;

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

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

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

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

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

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

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

27 (2) Home health care services;

28 (3) Clinic services;

29 (4) Dental services;

30 (5) Physical therapy and related services;

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

34 (7) Optometric services;

35 (8) Podiatric services;

36 (9) Chiropractic services;

37 (10) Psychological services;

38 (11) Inpatient psychiatric hospital services for individuals under
39 21 years of age, or under age 22 if they are receiving such services
40 immediately before attaining age 21;

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

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

46 (14) Intermediate care facility services;

47 (15) Transportation services;

48 (16) Services in connection with the inpatient or outpatient
49 treatment or care of substance use disorder, when the treatment is

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

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

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

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

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

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

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

46 (a) Expenses for diabetes self-management education or training to
47 ensure that a person with diabetes, gestational diabetes, or pre-diabetes
48 can optimize metabolic control, prevent and manage complications,

1 and maximize quality of life. Diabetes self-management education
2 shall be provided by an in-State provider who is:

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

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

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

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

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

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

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

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

48 (ii) incorporates the applicable information outlined in any best
49 practices manual for prenatal and postpartum maternal care developed

1 by the Department of Health into the curriculum for each group
2 prenatal visit;

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

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

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

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

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

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

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

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

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

44 (a) Information regarding the availability of the tobacco cessation
45 services described in this paragraph shall be provided to all individuals
46 authorized to receive the tobacco cessation services pursuant to this
47 paragraph at the following times: no later than 90 days after the
48 effective date of P.L.2019, c.473: upon the establishment of an

1 individual's eligibility for medical assistance; and upon the
2 redetermination of an individual's eligibility for medical assistance;

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

11 (c) Prior authorization requirements shall not be imposed on any
12 tobacco cessation services provided pursuant to this paragraph except
13 in the following circumstances where prior authorization may be
14 required: for a treatment that exceeds the duration recommended by
15 the most recently published United States Public Health Service
16 clinical practice guidelines on treating tobacco use and dependence; or
17 for services associated with more than two attempts to quit within a
18 12-month period;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (28) (a) medically necessary treatment for ²women with a
20 diagnosis of² perimenopause, menopause, and symptoms associated
21 with perimenopause and menopause, including but not limited to:

22 (i) hormonal therapies such as hormone replacement therapy and
23 bioidentical hormone treatments;

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

26 (iii) behavioral health care services;

27 (iv) pelvic floor physical therapy;

28 (v) bone health treatments, including screenings²[,] and²
29 medications ²[, and supplements,]² due to hormonal changes related
30 to perimenopause and menopause;

31 (vi) preventative services ²that have a rating of "A" or "B" in the
32 current recommendations of the United States Preventive Services
33 Task Force² for early detection and treatment of health conditions
34 related to perimenopause and menopause such as ²[, cardiovascular
35 disease,]² osteoporosis²[,]² and cancer; and

36 (vii) counseling and education regarding menopause management.

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

40 (c) As used in this paragraph:

41 "Menopause" means the ¹[, natural and]¹ permanent end of a
42 female's menstrual cycle, diagnosed by a licensed medical provider
43 after 12 consecutive months without a menstrual period.

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

47 c. Payments for the foregoing services, goods and supplies
48 furnished pursuant to this act shall be made to the extent authorized by

1 this act, the rules and regulations promulgated pursuant thereto and,
2 where applicable, subject to the agreement of insurance provided for
3 under this act. The payments shall constitute payment in full to the
4 provider on behalf of the recipient. Every provider making a claim for
5 payment pursuant to this act shall certify in writing on the claim
6 submitted that no additional amount will be charged to the recipient,
7 the recipient's family, the recipient's representative or others on the
8 recipient's behalf for the services, goods, and supplies furnished
9 pursuant to this act.

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

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

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

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

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

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

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

47 f. (1) A third party as defined in section 3 of P.L.1968, c.413
48 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in

1 this or another state when determining the person's eligibility for
2 enrollment or the provision of benefits by that third party.

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

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

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

19 (1) Pregnant women shall be provided prenatal care and delivery
20 services and postpartum care, including the services cited in
21 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
22 (10), (12), (15), and (17) of this section, and nursing facility services
23 cited in subsection b.(13) of this section.

24 (2) Dependent children shall be provided with services cited in
25 subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),
26 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing
27 facility services cited in subsection b.(13) of this section.

28 (3) Individuals who are 65 years of age or older shall be provided
29 with services cited in subsections a.(3) and (5) of this section and
30 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
31 (12), (15), and (17) of this section, and nursing facility services cited
32 in subsection b.(13) of this section.

33 (4) Individuals who are blind or disabled shall be provided with
34 services cited in subsections a.(3) and (5) of this section and
35 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), 3
36 (12), (15), and (17) of this section, and nursing facility services cited
37 in subsection b.(13) of this section.

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

48 (b) Outpatient hospital services, subsection a.(2) of this section,
49 shall only be provided to eligible medically needy individuals if the

1 federal Department of Health and Human Services discontinues the
2 State's waiver to establish outpatient hospital reimbursement rates for
3 the Medicare and Medicaid programs under the authority of section
4 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21
5 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be
6 extended to all or to certain medically needy individuals if the federal
7 Department of Health and Human Services directs that these services
8 be included. However, the use of outpatient hospital services shall be
9 limited to clinic services and to emergency room services for injuries
10 and significant acute medical conditions.

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

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

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

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

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

33 (cf: P.L.2023, c.187, s.1)

34

35 12. This act shall take effect on the 90th day next following
36 enactment and shall apply to policies and contracts that are delivered,
37 issued, executed or renewed on or after that date², except that policies
38 and contracts that are delivered, issued, executed or renewed pursuant
39 to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall be effective on January
40 1, 2027².