

[First Reprint]

**ASSEMBLY, No. 5278**

**STATE OF NEW JERSEY**  
**221st LEGISLATURE**

INTRODUCED FEBRUARY 10, 2025

**Sponsored by:**

**Assemblywoman HEATHER SIMMONS**

**District 3 (Cumberland, Gloucester and Salem)**

**Assemblyman ROY FREIMAN**

**District 16 (Hunterdon, Mercer, Middlesex and Somerset)**

**Assemblywoman LISA SWAIN**

**District 38 (Bergen)**

**Co-Sponsored by:**

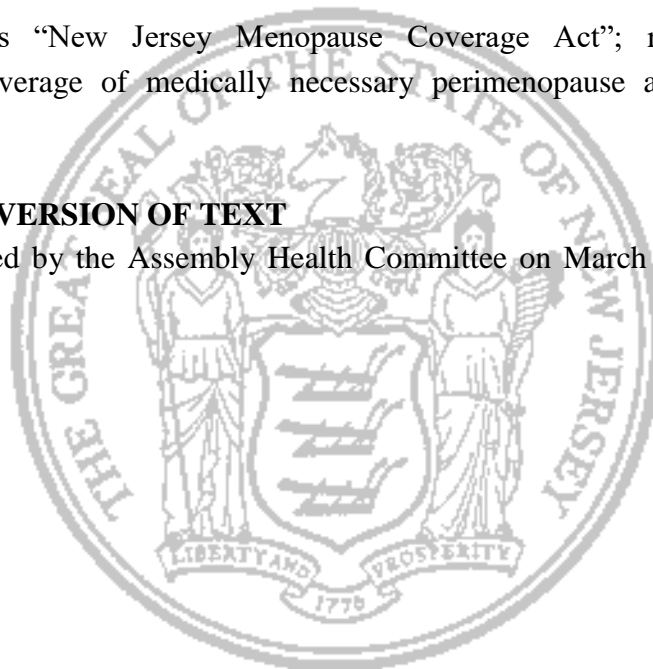
**Assemblywomen Reynolds-Jackson, Murphy, Carter, Drulis, Bagolie, Lopez, Ramirez, McCann Stamato, Kane, Morales, Assemblyman Bailey, Assemblywoman Haider, Assemblyman Miller and Assemblywoman Peterpaul**

**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 Health Committee on March 20, 2025, with amendments.



**(Sponsorship Updated As Of: 6/19/2025)**

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

19 (1) hormonal therapies such as hormone replacement therapy and  
20 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 screenings, medications, and  
26 supplements, due to hormonal changes related to perimenopause and  
27 menopause;

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

31 (7) counseling regarding menopause management.

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

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

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

40 e. As used in this section:

41 “Menopause” means the <sup>1</sup>**[natural and]**<sup>1</sup> permanent end of a  
42 female’s menstrual cycle, diagnosed by a licensed medical provider  
43 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:

<sup>1</sup>Assembly AHE committee amendments adopted March 20, 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 contract  
6 that provides hospital or medical expense benefits and is delivered,  
7 issued, executed or renewed in this State pursuant to P.L.1940, c.74  
8 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State  
9 by the Commissioner of Banking and Insurance on or after the  
10 effective date of P.L. , c. (C. ) (pending before the Legislature  
11 as this bill), shall provide benefits to any named subscriber or other  
12 person covered thereunder for expenses incurred in obtaining  
13 medically necessary treatment for perimenopause, menopause, and  
14 symptoms associated with perimenopause and menopause, including  
15 but not limited to:

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

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

20       (3) behavioral health care services;

21       (4) pelvic floor physical therapy;

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

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

28       (7) counseling and education regarding menopause management.

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

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

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

37       e. As used in this section:

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

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

44  
45       3. (New section) a. Every health service corporation contract  
46 that provides hospital or medical expense benefits and is delivered,  
47 issued, executed or renewed in this State pursuant to P.L.1985, c.236  
48 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State  
49 by the Commissioner of Banking and Insurance on or after the

1 effective date of P.L. , c. (C. ) (pending before the Legislature  
2 as this bill), shall provide benefits to any named subscriber or other  
3 person covered thereunder for expenses incurred in obtaining  
4 medically necessary treatment for perimenopause, menopause, and  
5 symptoms associated with perimenopause and menopause, including  
6 but not limited to:

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

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

11 (3) behavioral health care services;

12 (4) pelvic floor physical therapy;

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

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

19 (7) counseling and education regarding menopause management.

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

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

25 d. The provisions of this section shall apply to all health service  
26 corporation contracts in which the health service corporation has  
27 reserved the right to change the premium.

28 e. As used in this section:

29 “Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> permanent end of a  
30 female’s menstrual cycle, diagnosed by a licensed medical provider  
31 after 12 consecutive months without a menstrual period.

32 “Perimenopause” means the transitional period leading to  
33 menopause, marked by fluctuating hormone levels and changes in  
34 menstrual cycles.

35

36 4. (New section) a. Every individual policy that provides  
37 hospital or medical expense benefits and is delivered, issued, executed  
38 or renewed in this State pursuant to N.J.S. 17B:26-1 et seq., or  
39 approved for issuance or renewal in this State by the Commissioner of  
40 Banking and Insurance on or after the effective date of  
41 P.L. , c. (C. ) (pending before the Legislature as this bill), shall  
42 provide benefits to any named insured or other person covered  
43 thereunder for expenses incurred in obtaining medically necessary  
44 treatment for perimenopause, menopause, and symptoms associated  
45 with perimenopause and menopause, including but not limited to:

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

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

- 1 (3) behavioral health care services;
  - 2 (4) pelvic floor physical therapy;
  - 3 (5) bone health treatments, including screenings, medications, and
  - 4 supplements, due to hormonal changes related to perimenopause and
  - 5 menopause;
  - 6 (6) preventative services for early detection and treatment of health
  - 7 conditions related to perimenopause and menopause such as
  - 8 cardiovascular disease, osteoporosis, and cancer; and
  - 9 (7) counseling and education regarding menopause management.
- 10 b. Every individual policy shall provide clear and accessible
- 11 information to insureds regarding covered perimenopause and
- 12 menopause treatments.
- 13 c. The benefits shall be provided to the same extent as for any
- 14 other medical condition under the policy.
- 15 d. The provisions of this section shall apply to all health insurance
- 16 policies in which the insurer has reserved the right to change the
- 17 premium.
- 18 e. As used in this section:
- 19 “Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> 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 5. (New section) a. Every group health policy that provides
- 27 hospital or medical expense benefits and is delivered, issued, executed
- 28 or renewed in this State pursuant to N.J.S.17B:27-26 et seq., or
- 29 approved for issuance or renewal in this State by the Commissioner of
- 30 Banking and Insurance on or after the effective date of
- 31 P.L. , c. (C. ) (pending before the Legislature as this bill), shall
- 32 provide benefits to any named insured or other person covered
- 33 thereunder for expenses incurred in obtaining medically necessary
- 34 treatment for perimenopause, menopause, and symptoms associated
- 35 with perimenopause and menopause, including but not limited to:
- 36 (1) hormonal therapies such as hormone replacement therapy and
  - 37 bioidentical hormone treatments;
  - 38 (2) non-hormonal treatments, including medications to manage
  - 39 menopausal symptoms;
  - 40 (3) behavioral health care services;
  - 41 (4) pelvic floor physical therapy;
  - 42 (5) bone health treatments, including screenings, medications, and
  - 43 supplements, due to hormonal changes related to perimenopause and
  - 44 menopause;
  - 45 (6) preventative services for early detection and treatment of health
  - 46 conditions related to perimenopause and menopause such as
  - 47 cardiovascular disease, osteoporosis, and cancer; and
  - 48 (7) counseling and education regarding menopause management.

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

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

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

8 e. As used in this section:

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

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

15

16 6. (New section) a. Every enrollee agreement that provides  
17 hospital or medical expense benefits and is delivered, issued, executed  
18 or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et  
19 seq.), or approved for issuance or renewal in this State by the  
20 Commissioner of Banking and Insurance on or after the effective date  
21 of P.L. , c. (C. ) (pending before the Legislature as this bill),  
22 shall provide benefits to any enrollee or other person covered  
23 thereunder for expenses incurred in obtaining medically necessary  
24 treatment related to perimenopause and menopause, including but not  
25 limited to:

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

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

30 (3) behavioral health care services;

31 (4) pelvic floor physical therapy;

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

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

38 (7) counseling and education regarding menopause management.

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

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

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

47 e. As used in this section:

1 “Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> permanent end of a  
2 female’s menstrual cycle, diagnosed by a licensed medical provider  
3 after 12 consecutive months without a menstrual period.

4 “Perimenopause” means the transitional period leading to  
5 menopause, marked by fluctuating hormone levels and changes in  
6 menstrual cycles.

7  
8 7. (New section) a. Every individual health benefits plan that  
9 provides hospital or medical expense benefits and is delivered, issued,  
10 executed or renewed in this State pursuant to P.L.1992, c.161  
11 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this  
12 State by the Commissioner of Banking and Insurance on or after the  
13 effective date of P.L. , c. (C. ) (pending before the Legislature  
14 as this bill), shall provide benefits to any person covered thereunder  
15 for expenses incurred in obtaining medically necessary treatment for  
16 perimenopause, menopause, and symptoms associated with  
17 perimenopause and menopause, including but not limited to:

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

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

22 (3) behavioral health care services;

23 (4) pelvic floor physical therapy;

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

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

30 (7) counseling and education regarding menopause management.

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

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

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

39 e. As used in this section:

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

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

46  
47 8. (New section) a. Every small employer health benefits plan  
48 that provides hospital or medical expense benefits and is delivered,  
49 issued, executed or renewed in this State pursuant to P.L.1992, c.162

1 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this  
2 State by the Commissioner of Banking and Insurance on or after the  
3 effective date of P.L. , c. (C. ) (pending before the Legislature  
4 as this bill), shall provide benefits to any person covered thereunder  
5 for expenses incurred in obtaining medically necessary treatment for  
6 perimenopause, menopause, and symptoms associated with  
7 perimenopause and menopause, including but not limited to:

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

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

12 (3) behavioral health care services;

13 (4) pelvic floor physical therapy;

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

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

20 (7) counseling and education regarding menopause management.

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

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

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

29 e. As used in this section:

30 “Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> permanent end of a  
31 female’s menstrual cycle, diagnosed by a licensed medical provider  
32 after 12 consecutive months without a menstrual period.

33 “Perimenopause” means the transitional period leading to  
34 menopause, marked by fluctuating hormone levels and changes in  
35 menstrual cycles.

36  
37 9. (New section) a. The State Health Benefits Commission shall  
38 ensure that every contract purchased by the commission on or after the  
39 effective date of P.L. , c. (C. ) (pending before the Legislature  
40 as this bill), that provides hospital or medical expense benefits, shall  
41 provide benefits to any person covered thereunder for expenses  
42 incurred in obtaining medically necessary treatment for  
43 perimenopause, menopause, and symptoms associated with  
44 perimenopause and menopause, including but not limited to:

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

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

49 (3) behavioral health care services;

- 1 (4) pelvic floor physical therapy;
- 2 (5) bone health treatments, including screenings, medications, and
- 3 supplements, due to hormonal changes related to perimenopause and
- 4 menopause;
- 5 (6) preventative services for early detection and treatment of health
- 6 conditions related to perimenopause and menopause such as
- 7 cardiovascular disease, osteoporosis, and cancer; and
- 8 (7) counseling and education regarding menopause management.

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

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

14 d. As used in this section:

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

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

21

22 10. (New section) a. The School Employees’ Health Benefits  
23 Commission shall ensure that every contract purchased by the  
24 commission on or after the effective date of P.L. , c. (C. )  
25 (pending before the Legislature as this bill), that provides hospital or  
26 medical expense benefits, shall provide benefits to any person covered  
27 thereunder for expenses incurred in obtaining medically necessary  
28 treatment for perimenopause, menopause, and symptoms associated  
29 with perimenopause and menopause, including but not limited to:

- 30 (1) hormonal therapies such as hormone replacement therapy and
- 31 bioidentical hormone treatments;
- 32 (2) non-hormonal treatments, including medications to manage
- 33 menopausal symptoms;
- 34 (3) behavioral health care services;
- 35 (4) pelvic floor physical therapy;
- 36 (5) bone health treatments, including screenings, medications, and
- 37 supplements, due to hormonal changes related to perimenopause and
- 38 menopause;
- 39 (6) preventative services for early detection and treatment of health
- 40 conditions related to perimenopause and menopause such as
- 41 cardiovascular disease, osteoporosis, and cancer; and
- 42 (7) counseling and education regarding menopause management.

43 b. The School Employees Health Benefits Commission shall  
44 ensure that each contract shall provide clear and accessible  
45 information to a covered person regarding covered perimenopause and  
46 menopause treatments.

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

49 d. As used in this section:

1 “Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> permanent end of a  
2 female’s menstrual cycle, diagnosed by a licensed medical provider  
3 after 12 consecutive months without a menstrual period.

4 “Perimenopause” means the transitional period leading to  
5 menopause, marked by fluctuating hormone levels and changes in  
6 menstrual cycles.

7  
8 11. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read as  
9 follows:

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

15 (1) Inpatient hospital services

16 (2) Outpatient hospital services;

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

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

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

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

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

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

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

43 (2) Home health care services;

44 (3) Clinic services;

45 (4) Dental services;

46 (5) Physical therapy and related services;

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

- 1 (7) Optometric services;
- 2 (8) Podiatric services;
- 3 (9) Chiropractic services;
- 4 (10) Psychological services;
- 5 (11) Inpatient psychiatric hospital services for individuals under 21
- 6 years of age, or under age 22 if they are receiving such services
- 7 immediately before attaining age 21;
- 8 (12) Other diagnostic, screening, preventative, and rehabilitative
- 9 services, and other remedial care;
- 10 (13) Inpatient hospital services, nursing facility services, and
- 11 immediate care facility services for individuals 65 years of age or over
- 12 in an institution for mental diseases;
- 13 (14) Intermediate care facility services;
- 14 (15) Transportation services;
- 15 (16) Services in connection with the inpatient or outpatient
- 16 treatment or care of substance use disorder, when the treatment is
- 17 prescribed by a physician and provided in a licensed hospital or in a
- 18 narcotic and substance use disorder treatment center approved by the
- 19 Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et.
- 20 seq.) and whose staff includes a medical director, and limited those
- 21 services eligible for federal financial participation under Title XIX of
- 22 the federal Social Security Act;
- 23 (17) Any other medical care and any other type of remedial care
- 24 recognized under State law, specified by the Secretary of the federal
- 25 Department of Health and Human Services, and approved by the
- 26 commissioner;
- 27 (18) Comprehensive maternity care, which may include: the basic
- 28 number of prenatal and postpartum visits recommended by the
- 29 American College of Obstetrics and Gynecology; additional prenatal
- 30 and postpartum visits that are medically necessary; necessary
- 31 laboratory, nutritional assessment and counseling, health education,
- 32 personal counseling, managed care, outreach, and follow-up services;
- 33 treatment of conditions which may complicate pregnancy doula care;
- 34 and physician or certified nurse midwife delivery services. For the
- 35 purposes of this paragraph, "doula" means a trained professional who
- 36 provides continuous physical, emotional, and informational support to
- 37 a mother before, during, and shortly after childbirth, to help her to
- 38 achieve the healthiest, most satisfying experience possible;
- 39 (19) Comprehensive pediatric care, which may include:
- 40 ambulatory, preventive, and primary care health services. The
- 41 preventive services shall include, at a minimum, the basic number of
- 42 preventive visits recommended by the American Academy of
- 43 Pediatrics;
- 44 (20) Services provided by a hospice which is participating in the
- 45 Medicare program established pursuant to Title XVIII of the Social
- 46 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
- 47 services shall be provided subject to approval of the Secretary of the
- 48 federal Department of Health and Human Services for federal
- 49 reimbursement;

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

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

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

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

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

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

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

48 (d) Expenses for any medically appropriate and necessary supplies  
49 and equipment recommended or prescribed by a physician, advanced

1 practice nurse, or physician assistant for the management and  
2 treatment of diabetes, gestational diabetes, or pre-diabetes, including,  
3 but not limited to: equipment and supplies for self-management of  
4 blood glucose; insulin pens; insulin pumps and related supplies; and  
5 other insulin delivery devices;

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

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

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

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

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

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

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

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

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

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

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

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

48 (25) Comprehensive tobacco cessation benefits to an individual  
49 who is 18 years of age or older, or who is pregnant. Coverage shall

1 include: brief and high intensity individual counseling, brief and high  
2 intensity group counseling, and telemedicine as defined by section 1 of  
3 P.L.2017, c.117 (C.45:1-61); all medications approved for tobacco  
4 cessation by the U.S. Food and Drug Administration; and other  
5 tobacco cessation counseling recommended by the Treating Tobacco  
6 Use and Dependence Clinical Practice Guideline issued by the U.S.  
7 Public Health Service. Notwithstanding the provisions of any other  
8 law, rule, or regulation to the contrary, and except as otherwise  
9 provided in this section:

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

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

25 (c) Prior authorization requirements shall not be imposed on any  
26 tobacco cessation services provided pursuant to this paragraph except  
27 in the following circumstances where prior authorization may be  
28 required: for a treatment that exceeds the duration recommended by  
29 the most recently published United States Public Health Service  
30 clinical practice guidelines on treating tobacco use and dependence; or  
31 for services associated with more than two attempts to quit within a  
32 12-month period;

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

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

46 (27) (a) Within 24 months of the effective date of P.L.2023, c.187  
47 (C.30:4D-6u et al.), and conditional on the receipt of all necessary  
48 federal approvals and the securing of federal financial participation  
49 pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u), community-

1 based palliative care benefits which shall include, but not be limited to,  
2 all of the following:

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

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

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

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

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

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

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

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

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

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

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

33 (28) (a) medically necessary treatment for perimenopause,  
34 menopause, and symptoms associated with perimenopause and  
35 menopause, including but not limited to:

36 (i) hormonal therapies such as hormone replacement therapy and  
37 bioidentical hormone treatments;

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

40 (iii) behavioral health care services;

41 (iv) pelvic floor physical therapy;

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

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

48 (vii) counseling and education regarding menopause management.

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

4       **(c) As used in this paragraph:**

5       **“Menopause” means the <sup>1</sup>[natural and]<sup>1</sup> permanent end of a**  
6 **female’s menstrual cycle, diagnosed by a licensed medical provider**  
7 **after 12 consecutive months without a menstrual period.**

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (1) Pregnant women shall be provided prenatal care and delivery  
32 services and postpartum care, including the services cited in  
33 subsections a.(1), (3), and (5) of this section and subsections b.(1)-  
34 (10), (12), (15), and (17) of this section, and nursing facility services  
35 cited in subsection b.(13) of this section.

36 (2) Dependent children shall be provided with services cited in  
37 subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),  
38 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing  
39 facility services cited in subsection b.(13) of this section.

40 (3) Individuals who are 65 years of age or older shall be provided  
41 with services cited in subsections a.(3) and (5) of this section and  
42 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),  
43 (12), (15), and (17) of this section, and nursing facility services cited  
44 in subsection b.(13) of this section.

45 (4) Individuals who are blind or disabled shall be provided with  
46 services cited in subsections a.(3) and (5) of this section and  
47 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), 3  
48 (12), (15), and (17) of this section, and nursing facility services cited  
49 in subsection b.(13) of this section.

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

11 (b) Outpatient hospital services, subsection a.(2) of this section,  
12 shall only be provided to eligible medically needy individuals if the  
13 federal Department of Health and Human Services discontinues the  
14 State's waiver to establish outpatient hospital reimbursement rates for  
15 the Medicare and Medicaid programs under the authority of section  
16 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21  
17 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be  
18 extended to all or to certain medically needy individuals if the federal  
19 Department of Health and Human Services directs that these services  
20 be included. However, the use of outpatient hospital services shall be  
21 limited to clinic services and to emergency room services for injuries  
22 and significant acute medical conditions.

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

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

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

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

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

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

46

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