SENATE, No. 3030

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED OCTOBER 8, 2020

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)
Senator LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)
Senator VIN GOPAL
District 11 (Monmouth)

Co-Sponsored by:
Senators Ruiz, Singleton, B.Smith, Turner, Codey and Cunningham

SYNOPSIS

"Reproductive Freedom Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 11/8/2021)

AN ACT concerning reproductive rights and autonomy, and supplementing, amending, and repealing various parts of the statutory law.

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

1. (New section) This act shall be known, and may be cited, as the "Reproductive Freedom Act."

2. (New section) a. The Legislature finds that:

(1) Access to safe and legal abortion care is essential to women's health, autonomy, and privacy and is central to the ability of women to participate equally in the economic and social life of the United States and the State of New Jersey.

(2) Abortion is one of the safest medical procedures performed in the United States. In March 2018, experts at the National Academies of Science, Engineering, and Medicine published a study confirming that scientific evidence consistently indicates that legal abortions in the United States are extremely safe.

(3) Legal abortion is a necessary component of reproductive health care, and the Legislature is committed to ensuring that all individuals in the State have proper access to abortion care. However, the enactment of legislation that merely recognizes the legality of abortion is not sufficient to ensure that abortion care will be provided as a central component of reproductive health care in New Jersey; rather, due to controversies surrounding abortion rights in the State and nation, the Legislature must take affirmative steps to ensure that the ability of individuals to access legal abortion services in the State is not unnecessarily restricted.

(4) Access to comprehensive reproductive health care before, during, and after giving birth, including access to contraception, abortion, and prenatal and postnatal care, must be provided to all persons, irrespective of sex designation or gender identity, including to transgender and non-binary individuals.

(5) Pregnant individuals should be able to make their own health care decisions throughout the course of their pregnancy, with the advice of health care professionals they trust and without government interference or fear of prosecution.

(6) Harmful consequences result from unnecessary health regulations that single out abortion providers or individuals who seek abortion services without conferring any health benefit or increasing the safety of abortion. Such medically unnecessary regulations effectively reduce the number of abortion providers, diminish the

availability of legal abortion services, and create harmful barriers and delays to care without providing any benefit to patients.

(7) The Commissioner of Human Services and the State Board of Medical Examiners have adopted rules and regulations, codified, respectively, in chapters 54 and 66 of Title 10 and chapter 35 of Title 13 of the New Jersey Administrative Code, which target abortion providers with medically unnecessary regulation, thereby conflicting with the purposes of P.L. , c. (C.) (pending before the Legislature as this bill).

(8) Restrictions placed on abortion services also often have a disparate impact that is predominantly felt by persons who already experience barriers to health care, including young women, women of color, women with disabilities, women with a low-income, women who live in rural areas, immigrants, and transgender and non-binary individuals. Persons of color, in particular, experience disparities across a wide range of reproductive health outcomes, including in the areas of infant and maternal mortality, unintended pregnancies, and access to preventive care. In light of this country's history of discrimination, which includes shameful incidents of forced sterilization against women of color and persons with disabilities, it is imperative for New Jersey to ensure that all individuals, going forward, including, but not limited to, individuals who are incarcerated, are living in government-funded institutions, or are otherwise under governmental control or supervision, have true reproductive choice and individual autonomy with respect to reproductive decision-making, have sufficient access to reproductive care and accurate information on reproductive issues, including abortion, and are able to access the full range of reproductive services free from discrimination and unnecessary barriers to care.

(9) Given the historic and continued attacks on abortion access at the federal level and in many of New Jersey's sister states, it is critical that New Jersey take legislative action to ensure that its residents and those who come to this State are able to exercise the fundamental rights to choose to use or refuse contraception or sterilization, to carry a pregnancy, to give birth, or to have an abortion, regardless of where they are domiciled.

(10) The New Jersey Supreme Court has held, in cases such as Right to Choose v. Byrne, 91 N.J. 287 (1982), and Planned Parenthood of Cent. N.J. v. Farmer, 165 N.J. 609 (2000), that Article I, paragraph 1 of the New Jersey Constitution protects the right to abortion and reproductive autonomy to an extent that exceeds the protections established under the United States Constitution. Consequently, this State has historically provided stronger protections for reproductive rights and autonomy than are provided by other states and the federal government.

b. The Legislature, therefore, declares that it is both reasonable and necessary for the State to enable, facilitate, support, and safeguard the provision of high quality, comprehensive reproductive

and sexual health care, including the full range of evidence-based information, counseling, and health care services, to all individuals in the State, and to enable, facilitate, support, and safeguard the ability of such individuals to access affordable and timely reproductive health care services and to engage in autonomous reproductive decision-making, in consultation with health care professionals of their choosing, without fear of prosecution, discrimination, or unnecessary barriers to care. To achieve those ends, it shall be the policy of this State to:

(1) explicitly guarantee, to every individual, the fundamental right to reproductive autonomy, which includes the right to contraception, the right to abortion, and the right to carry a pregnancy to term;

(2) enable all qualified health care professionals to provide abortion services in the State;

(3) require all insurance carriers to provide coverage both for abortion care and for a long-term supply of contraceptives; and

(4) invalidate, and prohibit the future adoption of, all laws, rules, regulations, ordinances, resolutions, policies, standards, or parts thereof, that conflict with the provisions or the express or implied purposes of P.L. c. (C.) (pending before the Legislature as this bill).

3. (New section) As used in P.L. c. (C.) (pending before the Legislature as this bill):

"Abortion" means any medical treatment, including, but not limited to, the prescription of medication, that is intended to cause the termination of a pregnancy, except for the purposes of increasing the probability of a live birth, removing an ectopic pregnancy, or managing a miscarriage.

"Health care professional" means a person who is licensed or otherwise authorized to provide health care services, pursuant to Title 45 of the Revised Statutes, including, but not limited to, a physician, advance practice nurse, physician assistant, certified midwife, or certified nurse midwife.

"Pregnancy" means the period of the human reproductive process beginning with the implantation of a fertilized egg.

"Public entity" means the State and any county, municipality, district, public authority, public agency, or other political subdivision or public body in the State.

"State" means the State and any office, department, branch, division, subdivision, bureau, board, commission, agency, instrumentality, or individual acting under color of law of the State, but shall not include any such entity that is statutorily authorized to sue and be sued.

4. (New section) a. Every individual present in the State, including, but not limited to, an individual who is under State control or supervision, shall have the fundamental right to:

(1) choose or refuse contraception or sterilization; and

(2) choose whether to carry a pregnancy, to give birth, or to have an abortion.

b. A physician or other health care professional, acting within the professional's lawful scope of practice and in compliance with all generally applicable regulations, shall be authorized to provide abortion care in this State.

c. A fertilized egg, embryo, or fetus shall not have independent rights under the laws of this State.

d. No public entity shall, in the regulation or provision of benefits, facilities, services, or information, deny or interfere with an individual's fundamental reproductive rights under subsection a. of this section or discriminate against an individual on the basis of the individual's exercise of fundamental reproductive rights under subsection a. of this section.

e. No individual shall be subject to prosecution or otherwise deprived of the individual's constitutional rights for:

(1) terminating or attempting to terminate the individual's own pregnancy; or

(2) acting or failing to act in any manner, with respect to the individual's own pregnancy, based on the potential or actual impact on the individual's own health or pregnancy.

f. In protecting or enforcing the fundamental reproductive rights established pursuant to this section, a public entity shall not discriminate on the basis of: sex, including, but not limited to, sex stereotypes, sexual orientation, perceived sexual orientation, gender identity or expression, or perceived gender identity or expression; disability; race; ethnicity; age; national origin; immigration status; religion; incarceration status; or economic status.

g. (1) This section shall apply to all public entity actions in the State and to all State laws, rules, regulations, ordinances, policies, procedures, and practices, whether established by statute or otherwise and whether adopted before or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill).

(2) Notwithstanding any other law, rule, or regulation to the contrary, no public entity shall enact or enforce any law, rule, regulation, ordinance, resolution, standard, or other provision having the force and effect of law that conflicts or is otherwise inconsistent with the provisions of, or the purposes or policies expressed or implied in, P.L. , c. (C.) (pending before the Legislature as this bill).

(3) The following rules and regulations are declared to be void, and shall be given no force or effect following the effective date of P.L. , c. (C.) (pending before the Legislature as this bill):

(a) all rules and regulations promulgated by the Board of Medical Examiners as of the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), or parts thereof, which specifically regulate and apply exclusively to the termination of pregnancy or are otherwise inconsistent or in conflict with the provisions or express or

implied purposes of P.L. , c. (C.) (pending before the Legislature as this bill), including, but not limited to, N.J.A.C.13:35-4.2 in its entirety;

(b) all rules and regulations promulgated by the Department of Human Services as of the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), or parts thereof, which limit coverage for abortion services based on the type of facility or professional that provides the services, or which are otherwise inconsistent or in conflict with the provisions or express or implied purposes of P.L. , c. (C.) (pending before the Legislature as this bill), including, but not limited to, relevant parts or subparts of N.J.A.C.10:54-5.43 and N.J.A.C.10:66-2.16; and

(c) any rules and regulations promulgated by any other State agency as of the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), or parts thereof, which are inconsistent or in conflict with the provisions or express or implied purposes of P.L. , c. (C.) (pending before the Legislature as this bill).

h. The provisions of this section shall be enforceable under the "New Jersey Civil Rights Act," P.L.2004, c.143 (C.10:6-1 et seq.) or in any other manner provided by law.

5. (New section) a. The New Jersey Department of Human Services shall establish and administer a program to reimburse the cost of prenatal, labor, and delivery care, as well as the cost of abortion care and contraceptives described in sections 7 and 18 of P.L. , c. (C.) (pending before the Legislature as this bill), for individuals who can become pregnant and would be eligible for medical assistance if not for the provisions of 8 U.S.C. s.1611 or 8 U.S.C. s.1612. This program shall incorporate any existing programs and funding streams that provide coverage or reimbursement for prenatal, labor, and delivery care provided to such individuals.

b. The Department of Human Services, in collaboration with other appropriate agencies, shall explore any and all opportunities to obtain federal financial participation to offset the costs of implementing this section, including but not limited to, waivers or demonstration projects authorized under Title X of the Public Health Service Act or Title XIX or XXI of the Social Security Act. However, the implementation of this section shall not be contingent upon the department's receipt of a waiver or other authorization to operate a demonstration project.

c. The State Legislature shall annually appropriate the amount necessary to pay the reasonable and necessary expenses associated with the operation of the program established under this section, which expenses shall be determined by the department.

6. (New section) a. The provisions of P.L. , c. (C.) (pending before the Legislature as this bill) shall be liberally

construed to effectuate the purposes specified in section 1 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. If any provision of P.L. , c. (C.) (pending before the Legislature as this bill) is deemed by a court to be inconsistent with, in conflict with, or contrary to, any other provision of law, the provision contained in P.L. , c. (C.) (pending before the Legislature as this bill) shall prevail over such other contradictory provision of law, and such other provision of law shall be deemed to be amended, superseded, or repealed to the extent necessary to reconcile the inconsistency or conflict and ensure the law's consistency with the provisions of P.L. , c. (C.) (pending before the Legislature as this bill).

c. If any provision of P.L. , c. (C.) (pending before the Legislature as this bill), or the application of such provision to any person or circumstance, is held to be unconstitutional, the remaining provisions of P.L. , c. (C.) (pending before the Legislature as this bill), and the application of the provision at issue to all other persons or circumstances, shall not be affected thereby.

7. (New section) a. Every individual or group hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the hospital service corporation shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the subscriber's ability to claim tax-exempt contributions and withdrawals from the subscriber's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements of this section, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage

required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to subscribers and prospective subscribers, and the hospital service corporation shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a hospital service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

8. (New section) a. Every individual or group medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the medical service corporation shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the subscriber's ability to claim tax-exempt contributions and withdrawals from the subscriber's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a medical service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to subscribers and prospective subscribers, and the medical service corporation shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be

determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a medical service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

9. (New section) a. Every individual or group health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the health service corporation shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the subscriber's ability to claim tax-exempt contributions and withdrawals from the subscriber's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a health service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to subscribers and prospective subscribers, and the health service corporation shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a health service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit

entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

10. (New section) a. Every individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A policy subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the individual health insurer shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under 26 U.S.C. s.223

c. A policy shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and an individual health insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to insureds and prospective insureds, and the individual health insurer shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing an individual health insurer to exclude coverage for care that is necessary to preserve the life or health of an insured. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

11. (New section) a. Every group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide benefits for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A policy subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the group health insurer shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under 26 U.S.C. s.223.

c. A policy shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a group health insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to insureds and prospective insureds, and the group health insurer shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a group health insurer to exclude coverage for care that is necessary to preserve the life or health of an insured. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

12. (New section) a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature

as this bill), shall provide benefits for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A health benefits plan subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the covered person's health savings account under 26 U.S.C. s.223.

c. A health benefits plan shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to covered persons and prospective covered persons, and the carrier shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a carrier to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

13. (New section) a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide benefits for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A health benefits plan subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the

carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the covered person's health savings account under 26 U.S.C. s.223.

c. A health benefits plan shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Commissioner of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to covered persons and prospective covered persons, and the carrier shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a carrier to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

14. (New section) a. Every enrollee agreement that is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), shall provide health care services for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the health maintenance organization shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Department of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to enrollees and prospective enrollees, and the health maintenance organization shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a health maintenance organization to exclude coverage for care that is necessary to preserve the life or health of an enrollee. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

15. (New section) a. The State Health Benefits Commission shall ensure that every contract providing hospital or medical expense benefits, which is purchased by the commission on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), provides coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the commission shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the covered person's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section, if the Department of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

16. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract providing hospital or medical expense benefits, which is purchased by the commission on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), provides coverage for abortion, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

b. A contract subject to this section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under this section. For a qualifying high-deductible health plan for a health savings account, the commission shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the covered person's health savings account under 26 U.S.C. s.223.

c. A contract shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

d. Notwithstanding the provisions of subsections a. through c. of this section to the contrary, if the Department of Banking and Insurance concludes that enforcement of this section may adversely affect the allocation of federal funds to this State, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

e. A religious employer may request, and the School Employees' Health Benefits Commission shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to covered persons and prospective covered persons, and the School Employees' Health Benefits Commission shall provide notice to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing the School Employees' Health Benefits Commission to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

17. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract providing hospital or medical expense benefits, which is purchased by the commission on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), provides benefits for expenses incurred in the purchase of contraceptives and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a covered person's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the covered person's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the contract shall specify that no deductible, coinsurance, copayment, or any other cost-sharing requirement may be imposed on the coverage required pursuant to this section.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

e. A religious employer may request, and the commission shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to covered persons and prospective covered persons, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The commission shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing the School Employees' Health Benefits Commission to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

f. Except as otherwise authorized under this section, the School Employees' Health Benefits Commission shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

18. Section 1 of P.L.1965, c.217 (C.9:17A-1) is amended to read as follows:

1. The consent to the performance of medical or surgical care and **[**procedure**]** procedures by a hospital or by a **[**physician licensed to practice medicine and surgery**]** health care professional, as defined by section 3 of P.L. , c. (C.) (pending before the Legislature as this bill), which consent is executed by a married person who is a minor, or by a pregnant **[**woman**]** person who is a minor, on **[**his or her**]** the minor's behalf or on behalf of any of **[**his or her**]** the minor's children, shall be valid and binding, and, for such purposes, a married person who is a minor or a pregnant **[**woman**]** person who is a minor shall be deemed to have the same legal capacity to act and shall have the same powers and obligations as **[**has**]** a person of legal age. Notwithstanding any other provision of the law, an unmarried, pregnant minor may give consent to the furnishing of hospital, medical, and surgical care related to **[**her**]** the minor's pregnancy or **[**her**]** the minor's child**[**, although prior notification of a parent may be required pursuant to P.L.1999, c.145 (C.9:17A-1.1 et al.)**]** and

such consent shall not be subject to disaffirmance because of minority. The consent of the parent or parents of an unmarried, pregnant minor shall not be necessary in order to authorize hospital, medical, and surgical care related to **[**her**]** the minor's pregnancy or **[**her**]** the minor's child.
(cf: P.L.1999, c.145, s.1)

19. Section 1 of P.L.2005, c.251 (C.17:48-6ee) is amended to read as follows:

1. a. A hospital service corporation that provides hospital or medical expense benefits shall provide coverage, under every contract that is delivered, issued, executed, or renewed in this State or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this **[**act**]** section, for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those contracts in which the hospital service corporation has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to subscribers and prospective subscribers, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The hospital service corporation shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and

manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a hospital service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

g. Except as otherwise authorized under this section, a hospital service corporation shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.1)

20. Section 2 of P.L.2005, c.251 (C.17:48A-7bb) is amended to read as follows:

2. a. A medical service corporation that provides hospital or medical expense benefits shall provide coverage, under every contract that is delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this **[**act**]** section, for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those contracts in which the medical service corporation has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a medical service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer’s bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall

provide written notice thereof to subscribers and prospective subscribers, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The medical service corporation shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a medical service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

g. Except as otherwise authorized under this section, a medical service corporation shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.2)

21. Section 3 of P.L.2005, c.251 (C.17:48E-35.29) is amended to read as follows:

3. a. A health service corporation that provides hospital or medical expense benefits shall provide coverage, under every contract that is delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this **[**act**]** section, for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those contracts in which the health service corporation has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a health service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to subscribers and prospective subscribers, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The health service corporation shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a health service corporation to exclude coverage for care that is necessary to preserve the life or health of a subscriber. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

g. Except as otherwise authorized under this section, a health service corporation shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.3)

22. Section 9 of P.L.2005, c.251 (C.17:48F-13.2) is amended to read as follows:

9. a. A prepaid prescription service organization shall provide coverage, on an in-network basis, under every contract delivered, issued, executed, or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance**[**,**]** on or after the effective date of this **[**act**]** section**[**,**]** for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the services, drugs, devices, products, and procedures **[**on an in-network basis as determined to be**]** required **[**to be covered**]** by the commissioner to be covered pursuant to subsection b. of this section.

b. The Commissioner of Banking and Insurance shall determine, in the commissioner's discretion, which provisions of the coverage requirements applicable to insurers pursuant to P.L.2019, c.361 shall apply to prepaid prescription organizations, and shall adopt regulations in accordance with the commissioner's determination.

c. The coverage provided under this section shall include prescriptions for dispensing contraceptives for**[**:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was

in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract**]** a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

d. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

e. This section shall apply to those prepaid prescription contracts in which the prepaid prescription service organization has reserved the right to change the premium.

f. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

g. A religious employer may request, and a prepaid prescription service organization shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to enrollees and prospective enrollees, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The prepaid prescription service organization shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a prepaid prescription service organization to exclude coverage for care that is necessary to preserve the life or health of an enrollee. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and

is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986 (26 U.S.C. s.6033), as amended.

h. Except as otherwise authorized under this section, a prepaid prescription service organization shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.9)

23. Section 5 of P.L.2005, c.251 (C.17B:26-2.1y) is amended to read as follows:

5. a. An individual health insurer that provides hospital or medical expense benefits shall provide coverage under every policy that is delivered, issued, executed, or renewed in this State or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this **[**act**]** section, for expenses incurred in the purchase of prescription female contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon **[**a subscriber's**]** an insured's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the **[**subscriber's**]** insured's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the policy was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the policy. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the policy, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those policies in which the insurer has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and an individual health insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to insureds and prospective insureds, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The individual health insurer shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this

subsection shall not be construed as authorizing an individual health insurer to exclude coverage for care that is necessary to preserve the life or health of an insured. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

g. Except as otherwise authorized under this section, an individual health insurer shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.5)

24. Section 4 of P.L.2005, c.251 (C.17B:27-46.1ee) is amended to read as follows:

4. a. A group health insurer that provides hospital or medical expense benefits shall provide coverage under every policy that is delivered, issued, executed, or renewed in this State or is approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this **[**act**]** section, for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon **[**a subscriber's**]** an insured's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the [subscriber's] insured's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the policy was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the policy. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the policy, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those policies in which the insurer has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a group health insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to insureds and prospective insureds, which notice shall list

the contraceptive health care services that the employer refuses to cover for religious reasons. The group health insurer shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a group health insurer to exclude coverage for care that is necessary to preserve the life or health of an insured. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

g. Except as otherwise authorized under this section, a group health insurer shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.4)

25. Section 7 of P.L.2005, c.251 (C.17B:27A-7.12) is amended to read as follows:

7. a. An individual health benefits plan required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall provide coverage for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a **[**subscriber's**]** covered person's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the [subscriber's] covered person's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the health benefits plan was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the health benefits plan. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the health benefits plan, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice

thereof to covered persons and prospective covered persons, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The carrier shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a carrier to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

g. Except as otherwise authorized under this section, a carrier shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.7)

26. Section 8 of P.L.2005, c.251 (C.17B:27A-19.15) is amended to read as follows:

8. a. A small employer health benefits plan required pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall provide coverage for expenses incurred in the purchase of ⟦prescription female⟧ contraceptives⟦,⟧ and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a ⟦subscriber's⟧ covered person's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the [subscriber's] covered person's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the health benefits plan was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the health benefits plan. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the health benefits plan, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious

employer that obtains such an exclusion shall provide written notice thereof to covered persons and prospective covered persons, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The carrier shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a carrier to exclude coverage for care that is necessary to preserve the life or health of a covered person. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

g. Except as otherwise authorized under this section, a carrier shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.8)

27. Section 6 of P.L.2005, c.251 (C.26:2J-4.30) is amended to read as follows:

6. a. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued, on or after the effective date of this **[**act for a health maintenance organization**]** section, unless the health maintenance organization provides health care services for prescription female contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a **[**subscriber's**]** enrollee's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the [subscriber's] enrollee's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the health care services provided under this section shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except that no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. The provisions of this section shall apply to those contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

f. A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to enrollees and prospective enrollees, which notice shall list the contraceptive health care services that the employer refuses to cover for religious reasons. The health maintenance organization shall provide notice of the exclusion to the Commissioner of Banking and Insurance in such form and manner as may be determined by the commissioner. The provisions of this subsection shall not be construed as authorizing a health maintenance organization to exclude coverage for care that is necessary to preserve the life or health of an enrollee. For the purposes of this subsection, "religious employer" means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

g. Except as otherwise authorized under this section, a health maintenance organization shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.6)

28. Section 10 of P.L.2018, c.62 (C.26:6B-10) is amended to read as follows:

10. a. A medical examiner shall conduct a medicolegal investigation of a death in this State, as determined to be necessary to establish identity and the cause and manner of death, and to resolve any issues or potential issues of public health and of legal concern, in accordance with rules and regulations adopted by the Chief State Medical Examiner, in any of the following instances:

(1) death where criminal violence appears to have taken place, regardless of the time interval between the incident and death, and regardless of whether the violence appears to have been the immediate cause of death, or a contributory factor thereto;

(2) death by accident or unintentional injury, regardless of the time interval between the incident and death, and regardless of whether the injury appears to have been the immediate cause of death**[**,**]** or a contributory factor thereto;

(3) death under suspicious or unusual circumstances;

(4) death from causes that might constitute a threat to public health or safety;

(5) death not caused by readily recognizable diseases, disability, or infirmity;

(6) sudden death when the decedent was in apparent good health;

(7) suicide;

(8) death of a child under 18 years of age from any cause;

(9) sudden or unexpected death of an infant or child under three years of age [or a fetal death occurring without medical attendance];

(10) death where suspicion of abuse of a child, family or household member, or elderly or disabled person exists;

(11) death within 24 hours of admission to a hospital or a nursing home;

(12) death in custody, in a jail or correctional facility, or in a State or county psychiatric hospital, State developmental center, or other public or private institution or facility for persons with mental illness, developmental disabilities, or brain injury;

(13) death related to occupational illness or injury;

(14) death due to thermal, chemical, electrical, or radiation injury;

(15) death due to toxins, poisons, medicinal or recreational drugs, or a combination thereof;

(16) known or suspected non-natural death;

(17) any person found dead under unexplained circumstances;

(18) the discovery of skeletal remains;

(19) death for which investigation is in the public interest; or

(20) [a] death occurring under such other circumstances as prescribed by regulation of the Chief State Medical Examiner.

b. For a death that occurs, or appears to have occurred, for any of the reasons specified in subsection a. of this section:

(1) It shall be the duty of any member of the general public having knowledge of the death to notify immediately the local law enforcement agency of the known facts concerning the time, place, manner, and circumstances of that death;

(2) It shall be the duty of any attending physician, licensed nurse, hospital administrator, law enforcement officer, Department of Children and Families staff member, or funeral director to notify immediately the county or intercounty medical examiner of the known facts concerning the time, place, manner, and circumstances of that death; and

(3) A person who willfully neglects or refuses to report the death[,] or who, without an order from the office of the county or intercounty medical examiner or the Office of the Chief State Medical Examiner, willfully touches, removes, or disturbs the decedent's body or touches, removes, or disturbs the clothing upon or near the body, is guilty of a crime of the fourth degree.

c. In addition to the rules and regulations adopted by the Chief State Medical Examiner establishing uniform procedures for conducting medicolegal death investigations, the procedures concerning the death investigation process as set forth in this subsection shall be followed by the persons specified herein.

(1) Upon the death of a person from any of the causes specified in subsection a. of this section, it shall be the duty of the physician in attendance, a law enforcement officer having knowledge of the death, the funeral director, or any other person present, to immediately

notify the county or intercounty medical examiner and the county prosecutor of the county in which the death occurred of the known facts concerning the time, place, manner, and circumstances of that death. Upon receipt of that notification, the county or intercounty medical examiner, **[**or**]** an assistant county or intercounty medical examiner, or a medicolegal death investigator shall immediately proceed to the place where the dead body is located and take charge of the body. A medicolegal death investigator who engages in the investigation of deaths pursuant to this subsection shall obtain certification from the American Board of Medicolegal Death Investigators within three years after the effective date of **[**this act**]** P.L.2018, c.62 (C.26:6B-1 et al.), or within three years after the person first takes action under this paragraph, whichever is later.

(2) In cases of apparent homicide or suicide, or in cases of accidental death, the cause of which is obscure, the scene of the event shall not be disturbed until the medical examiner or medicolegal death investigator in charge provides authorization to do so.

(3) (a) The medical examiner or medicolegal death investigator, as the case may be, shall: fully investigate the essential facts concerning the medical causes of death and take the names and addresses of as many witnesses thereto as may be practicable to obtain; before leaving the premises, reduce those facts, as the medical examiner may deem necessary, to writing; file those facts in the office of the county or intercounty medical examiner; and make the facts available to the county prosecutor and the Chief State Medical Examiner at their request.

(b) The law enforcement officer present at the investigation, or the medical examiner or medicolegal death investigator if no officer is present, shall, in the absence of the next-of-kin of the deceased person: take possession of all property of value found on the decedent; **[**make**]** include an exact inventory thereof **[**on his**]** in the medical examiner's or medicolegal death investigator's official report; and deliver the property to the law enforcement agency for the municipality in which the death occurred, which shall surrender the property to the person entitled to its custody or possession.

(c) The medical examiner or medicolegal death investigator, as the case may be, shall take possession of any objects or articles that, in **[**his**]** the opinion of the medical examiner or medicolegal death investigator, may be useful in establishing the cause or manner of death, or which constitute evidence of criminal behavior, and, after cataloging each item, shall deliver them to the county prosecutor.

(4) The Chief State Medical Examiner, Deputy Chief State Medical Examiner, county or intercounty medical examiner, assistant county or intercounty medical examiner, or medicolegal death investigator, as the case may be, shall consult with law enforcement officers and agencies, county prosecutors, public health agencies, **[**or**]** and other appropriate entities in matters within their expertise,

when conducting a medicolegal death investigation. The medical examiner, assistant medical examiner, or medicolegal death investigator, as the case may be, shall be provided with an Originating Agency Identification Number[,] and access to the State's motor vehicle registries and fingerprint registries[,] for the purposes of identifying the remains of a deceased individual under this section.

(5) If the cause of death is established within a reasonable degree of medical certainty and no autopsy is deemed necessary, the county or intercounty medical examiner, assistant county or intercounty medical examiner, or medicolegal death investigator, as the case may be, shall reduce the findings to writing and promptly make a full report thereof to the Chief State Medical Examiner and to the county prosecutor in a format to be prescribed by the Chief State Medical Examiner for that purpose.

(6) If, in the opinion of the county or intercounty medical examiner, the Chief State Medical Examiner, an assignment judge of the Superior Court, the county prosecutor, the Attorney General, or the commissioner, an autopsy is deemed necessary, the autopsy shall be performed by:

(a) the county or intercounty medical examiner or assistant county or intercounty medical examiner, provided that the individual performing the autopsy is under the supervision of a pathologist certified by the American Board of Pathology or the American Osteopathic Board of Pathology;

(b) the Chief State Medical Examiner, at his or her discretion, or the Deputy Chief State Medical Examiner; or

(c) such competent forensic pathologists as may be authorized by the Chief State Medical Examiner.

(7) If, in any case in which the suspected cause of death of a child under one year of age is sudden infant death syndrome[,] or the death of a child [is] between one and three years of age [and the death] is sudden and unexpected, and an investigation has been conducted in accordance with the provisions of this section, and [a] the child's parent or legal guardian [of the child] requests an autopsy, an autopsy shall be performed by: (a) the county or intercounty medical examiner or assistant county or intercounty medical examiner, provided that the individual performing the autopsy is under the supervision of a pathologist certified by the American Board of Pathology or the American Osteopathic Board of Pathology; or (b) the Chief State Medical Examiner, at his or her discretion, or the Deputy Chief State Medical Examiner.

(a) The medical examiner performing the autopsy shall file a detailed description of the findings and conclusions of the autopsy with the Office of the Chief State Medical Examiner, [and with] the appropriate county or intercounty medical examiner office, and the county prosecutor.

(b) Upon the request of a parent or legal guardian of the child, a pediatric pathologist, if available, shall assist in the performance of the autopsy under the direction of a forensic pathologist. The Chief State Medical Examiner or county or intercounty medical examiner shall notify the parent or legal guardian of the child that **[**they**]** the parent or guardian may request that a pediatric pathologist assist in the performance of the autopsy. The medical examiner shall include any findings and conclusions by the pathologist from the autopsy with the information filed with the Office of the Chief State Medical Examiner, **[**and with**]** the appropriate county or intercounty medical examiner office, and the county prosecutor, pursuant to subparagraph (a) of this paragraph. The Chief State Medical Examiner or the county or intercounty medical examiner shall make available a copy of these findings and conclusions to the closest surviving relative of the decedent within 120 days of the receipt of a request therefor, unless the death is under active investigation by a law enforcement agency.

(c) The medical examiner **[**with**]** having jurisdiction **[**for**]** over the investigation shall make the preliminary findings and conclusions of the autopsy available to the child's parent or legal guardian and the department within 48 hours after the medical examiner is notified of the death of the child. The medical examiner shall provide his or her findings and conclusions for each reported case to the department upon completion of the investigation.

(8) Notwithstanding the provisions of **[**this act**]** P.L.2018, c.62 (C.26:6B-1 et al.) to the contrary, a county or intercounty medical examiner may request the Chief State Medical Examiner **[**or**]**, Deputy Chief State Medical Examiner, or other person authorized and designated by the Chief State Medical Examiner**[**,**]** to conduct an examination or perform an autopsy whenever it is deemed necessary or desirable.

(9) In the case of the death of a resident of a long-term care facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a State psychiatric hospital operated by the Department of Health and listed in R.S.30:1-7, a county psychiatric hospital, a facility for persons with developmental disabilities as defined in section 3 of P.L.1977, c.82 (C.30:6D-3), or a facility for persons with traumatic brain injury as defined in 42 U.S.C. s.280b-1c that is operated by or under contract with the Department of Human Services, the psychiatric hospital or facility, as the case may be, shall, in addition to notifying the next-of-kin of the resident's death, so notify the county or intercounty medical examiner and provide that individual with contact information for the resident's next-of-kin. The county or intercounty medical examiner**[**,**]** or assistant county or intercounty medical examiner **[**on his behalf**]**, shall make every practicable effort to contact the resident's next-of-kin to offer that person the opportunity to provide the medical

examiner with information that the person deems relevant to: the circumstances of the resident's death; and whether there is a need to perform a dissection or autopsy of the decedent.

d. Upon the request of a decedent's legal representative, or upon the request of the person who, pursuant to section 22 of P.L.2003, c.261 (C.45:27-22), is in control of the decedent's funeral, the Chief State Medical Examiner shall provide the legal representative or person in control of the funeral with all available documentation related to the decedent's autopsy and the medical investigation of the decedent's death.

(cf: P.L.2018, c.62, s.10)

29. Section 10 of P.L.2005, c.251 (C.52:14-17.29j) is amended to read as follows:

10. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this **[**act shall provide**]** section provides benefits for expenses incurred in the purchase of **[**prescription female**]** contraceptives**[**,**]** and the following services, drugs, devices, products, and procedures, on an in-network basis:

(1) Any contraceptive drug, device, or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a **[**subscriber's**]** covered person's choice of contraception, and medical necessity shall be determined by the provider for covered contraceptive drugs, devices, or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products, and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the **[**subscriber's**]** covered person's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided under this section shall include prescriptions for dispensing contraceptives for[:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract] a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period if a 12-month period would extend beyond the terms of the contract. The contraceptives may be furnished over the course of the 12-month period at the discretion of the health care provider.

c. (1) Except as provided in paragraph (2) of this subsection, the contract shall specify that no deductible, coinsurance, copayment, or any other cost-sharing requirement may be imposed on the coverage required pursuant to this section.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

e. Except as otherwise authorized by this section, the State Health Benefits Commission shall not impose any restrictions or delays on, and shall not require prior authorization for, the coverage required under this section.

(cf: P.L.2019, c.361, s.10)

30. The following sections are repealed:

Sections 1 through 3 of P.L.1997, c.262 (C.2A:65A-5 through C.2A:65A-7); and

Sections 2 through 13 of P.L.1999, c.145 (C.9:17A-1.1 through C.9:17A-1.12).

31. The Commissioners of Human Services and Banking and Insurance shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of this act. Each professional licensing board operating under the authority of the Division of Consumer Affairs in the Department of Law and Public Safety shall additionally adopt rules and regulations, pursuant to the "Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.), with respect to the health care professionals under each licensing board's respective jurisdiction, as may be necessary to implement the provisions of this act. The rules and regulations adopted by the Commissioner of Human Services, pursuant to this section, shall include, but need not be limited to, rules and regulations permitting electronic billing for abortion services, which rules and regulations shall be promulgated by January 1, 2022.

32. This act shall take effect immediately, except that sections 7 through 16, sections 18 through 26, and section 28 shall take effect on the 60th day after enactment and shall apply to all contracts, plans, and policies delivered, issued, executed, or renewed on or after that date, and section 5 shall take effect one year after the date of enactment. The Department of Banking and Insurance may take anticipatory administrative action, in advance of the effective date specified for sections 7 through 16, sections 18 through 26, and section 28 of this act, as may be necessary to implement those provisions, and the Department of Human Services and any cooperating agencies may take anticipatory administrative action, in advance of the effective date specified for section 5 of this act, as may be necessary to implement the provisions of that section.

STATEMENT

This bill, to be known as the "Reproductive Freedom Act," would make various changes to the law to facilitate and safeguard the individual right to reproductive autonomy in the State.

The State Supreme Court has held that the New Jersey Constitution protects the right to reproductive autonomy and choice, including the right to choose abortion, to an extent that exceeds the protections found in the federal Constitution. Although the right to reproductive choice and autonomy, including the right to choose abortion, is not specifically expressed within the text of the State Constitution, the Supreme Court has concluded that the right to reproductive autonomy derives from the provisions of Article I, paragraph 1 of the State Constitution, which provide extensive protections for individual liberty and privacy to an extent that exceeds the protections established under the United States Constitution.

This bill would make it express, within the State's statutory law, that every individual in the State, regardless of whether they are domiciled in the State, and regardless of whether or not the individual is under State control, has a fundamental right to: 1) choose or refuse contraception or sterilization; and 2) choose whether to carry a pregnancy, to give birth, or to have an abortion. Under the bill's provisions, no individual would be subject to prosecution or otherwise deprived of their individual constitutional rights for terminating or attempting to terminate the individual's own pregnancy or for acting or failing to act, in any manner, with respect to the individual's own pregnancy, based on the potential or actual impact on the individual's own health or pregnancy.

The bill specifies that no public entity may, in the regulation or provision of benefits, facilities, services, or information, deny or interfere with an individual's fundamental reproductive rights, as expressed in the bill. The bill further provides that, in protecting or enforcing the fundamental reproductive rights recognized by the bill, a public entity may not discriminate on the basis of: sex, including, but not limited to, sex stereotypes, sexual orientation, perceived sexual orientation, gender identity or expression, or perceived gender identity or expression; disability; race; ethnicity; age; national origin; immigration status; religion; incarceration status; or economic status.

The bill specifies that a fertilized egg, embryo, or fetus may not be understood to have independent rights under any of the laws of this State, and it further specifies that any health care professional, acting within the professional's lawful scope of practice and in compliance with generally applicable regulations, is authorized to provide abortion care.

Current regulations of the State Board of Medical Examiners and the Commissioner of Human Services, which are codified in Titles 10 and 13 of the New Jersey Administrative Code, specifically regulate the procedures that may be used in the termination of pregnancy and limit coverage for abortion based on the type of facility and professional that provides the abortion services. Because these existing regulations are medically unnecessary forms of abortion regulation, which conflict with the purposes of the bill, the bill would specify that, following its effective date, these and all other rules or regulations that specifically regulate and apply exclusively to the termination of pregnancy or are otherwise inconsistent or in conflict with the provisions or express or implied purposes of the bill will become void, inoperable, and unenforceable.

Any person who is aggrieved by an action that is undertaken in violation of the bill's provisions will be entitled to bring suit under the "New Jersey Civil Rights Act," P.L.2004, c.143 (C.10:6-1 et seq.) or to enforce the bill's provisions in any other manner provided by law.

In addition to recognizing an individual's fundamental rights to reproductive autonomy and choice, the bill also requires all providers

of health insurance (including hospital service corporations, medical service corporations, health service corporations, individual and group health insurance carriers, individual and group health benefits plans, the State Health Benefits Commission, and the School Employees' Health Benefits Commission) to provide coverage for abortion. An insurance contract, policy, or plan may not impose any restrictions or delays on, and may not require prior authorization for, the abortion coverage required by the bill. An insurance contract, policy, or plan also may not impose any deductible, coinsurance, copayment, or other cost-sharing requirement on the coverage required by the bill and, for a qualifying high-deductible health plan for a health savings account, the cost-sharing for coverage is to be set at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the covered person's health savings account under 26 U.S.C. s.223.

Notwithstanding the bill's insurance coverage requirements, if the Commissioner of Banking and Insurance concludes that the provision of insurance coverage for abortion, in accordance with the bill, might adversely affect the allocation of federal funds to the State, the commissioner may grant an exemption to the coverage requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds. In addition, the bill provides that religious employers will be eligible to request and obtain an exclusion from the bill's abortion coverage requirements if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion will be required to provide written notice thereof to covered persons and prospective covered persons. The bill specifies, however, that nothing in its provisions may be construed as authorizing an insurance carrier to exclude coverage for abortion care that is necessary to preserve the life or health of the covered person.

The bill also amends the existing insurance laws that pertain to the provision of coverage for contraceptive care in order to require coverage for the dispensing of a single dispensing unit of up to a 13-unit supply of prescription contraceptives, intended to last over a 12-month period, regardless of whether coverage was in effect at the time of the first dispensing, and except in cases where a 12-month supply would extend beyond the terms of the insurance contract, policy, or plan. Current law requires coverage for only a three-month period in association with the first dispensing of a contraceptive and for a six-month period in association with any subsequent dispensing of the same contraceptive. The bill authorizes the contraceptives to be furnished over the course of the 12-month period at the discretion of the health care provider, and it prohibits an insurance carrier from imposing any restrictions or delays on, or requiring any prior authorization for, the provision of contraceptive coverage.

Like the bill's provisions pertaining to insurance coverage for abortion, the bill authorizes a religious employer to request and

obtain an exclusion from the bill's contraceptive coverage requirements if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion will need to provide written notice thereof to covered persons and prospective covered persons, which notice is to list the contraceptive health care services that the employer refuses to cover for religious reasons. Nothing in the bill's provisions may be deemed to authorize an insurance carrier to exclude coverage for contraceptive care that is necessary to preserve the life or health of the covered person.

In addition to amending the existing laws pertaining to contraceptive coverage, the bill would supplement the existing law in order to require the School Employees' Health Benefits Commission to provide coverage for contraceptives to the same extent as is required of all other insurance carriers under the bill's provisions. Existing law does not require the School Employees' Health Benefits Commission to provide coverage for contraceptives, despite the fact that all other insurance carriers are required to provide such coverage.

The bill further requires the Department of Human Services (DHS) to establish and administer a program to reimburse the cost of prenatal, labor, and delivery care, as well as abortion care and contraceptives, which are provided by a hospital service corporation to individuals who can become pregnant and would be eligible for medical assistance if not for the provisions of 8 U.S.C. s.1611 or 8 U.S.C. s.1612, which provisions prohibit certain immigrants from obtaining public benefits. The reimbursement program is to incorporate any existing programs and funding streams that provide coverage or reimbursement for prenatal, labor, and delivery care received by relevant immigrants. The DHS, in collaboration with other appropriate agencies, will be required to explore any and all opportunities to obtain federal financial participation to offset the costs of implementing the reimbursement program; however, the implementation of the program will not be contingent upon the department's receipt of a waiver or other authorization from the federal government to operate a demonstration project. The bill would provide for the State Legislature to annually appropriate the amount necessary to pay the reasonable and necessary expenses of the program, which expenses are to be determined by the DHS.

The bill requires both the Commissioner of Human Services and the Commissioner of Banking and Insurance to adopt rules and regulations to implement the bill's provisions. The bill additionally requires each professional licensing board operating under the authority of the Division of Consumer Affairs in the Department of Law and Public Safety to adopt rules and regulations, pursuant to the "Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.), with respect to the health care professionals under each licensing board's respective jurisdiction, as may be necessary to

implement the bill's provisions. The rules and regulations adopted by the Commissioner of Human Services under the bill are to include, but need not be limited to, rules and regulations permitting electronic billing for abortion services, which rules and regulations are to be promulgated by January 1, 2022.

The bill specifies that it is to be liberally construed to effectuate its purposes. If any provision of the bill is deemed by a court to be inconsistent with, in conflict with, or contrary to, any other provision of law, the provision contained in the bill will prevail over the other, contradictory, provision of law, and such other provision of law is to be deemed amended, superseded, or repealed to the extent necessary to reconcile the inconsistency or conflict and ensure the law's consistency with the provisions of the bill. If any provision of the bill, or the application thereof to any person or circumstance, is held to be unconstitutional, the remaining provisions of the bill, and the application of the provision at issue to all other persons or circumstances, will not be affected thereby.

The bill would amend the existing law pertaining to autopsies and medicolegal death investigations to eliminate the requirement that a medicolegal death investigation be conducted in a case where a fetal death occurs without medical attendance. The bill would also repeal the "Partial Birth Abortion Ban Act of 1997," sections 1 through 3 of P.L.1997, c.262 (C.2A:65A-5 through C.2A:65A-7), and the "Parental Notification for Abortion Act," sections 2 through 13 of P.L.1999, c.145 (C.9:17A-1.1 through C.9:17A-1.12), each of which has been found by the New Jersey Supreme Court to be unconstitutional, void, and unenforceable. Finally, the bill would amend the law at section 1 of P.L.1999, c.145 (C.9:17A-1), which governs the consent of minors to medical treatment, in order to eliminate a cross-reference to the "Parental Notification for Abortion Act" and thereby ensure that the statutory law conforms to the existing case law in this area, which allows an unmarried, pregnant minor to give consent to the furnishing of hospital, medical, and surgical care related to her pregnancy or child, without the need to notify her parents.