

# A STUDY OF NEW JERSEY ASSEMBLY BILL 5609

REQUIRES HEALTH INSURANCE CARRIERS AND  
MEDICAID TO PROVIDE COVERAGE FOR  
PLANNED HOME CHILDBIRTH

Report to the New Jersey Assembly

February 6, 2026

Mandated Health Benefits Advisory Commission



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Appendix I    Assembly Bill No. 5609

Appendix II    Review Request for Assembly Bill No. 5609

## INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review Assembly Bill No. 5609 (see Appendix I for a copy of the legislation), a bill that “Requires health insurance carriers and Medicaid to provide coverage for planned home childbirth.” The bill would apply to health insurance carriers, including insurance companies, health service corporations, hospital service corporations, medical service corporations, individual health insurance policies, group health insurance policies, small employer health benefits plans, health maintenance organizations (HMOs), the State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP), and the State Medicaid and NJ FamilyCare programs.\*

Assembly Bill No. 5609 (A5609) states that “coverage shall be provided to the same extent as for any other health care services under the...contract.” The bill mandates “coverage for costs associated with planned home childbirth, including, but not limited to, services provided by a health care provider, services provided by a doula, and equipment and medical supplies.” Finally, A5609’s definition of health care provider “includes a family practice physician, obstetrician, advanced practice nurse, registered professional nurse, licensed practical nurse, certified professional midwife, certified nurse midwife, or certified midwife.”

A companion bill, S1097, was introduced in the New Jersey Senate and referred to the Senate Health, Human Services and Senior Citizens Committee. The bill was reported as Senate Committee Substitute for S1097 and referred to the Senate Budget and Appropriations Committee (SBA). The SBA favorably reported S1097 (SCS) on December 9, 2024, and the bill passed the Senate on December 22, 2025.

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The Act does not ask the Commission to recommend whether to enact the legislation, and the Commission does not do so here. The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections. The MHBAC has sought to include information from a number of reputable sources that it found credible but recognizes that opinions and analyses may differ.

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\* Pursuant to the Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1 *et seq.*), the Commission’s review is limited to the application of mandates to the commercial market. Accordingly, this report does not directly address how the coverage mandate would potentially impact the Medicaid or NJ FamilyCare Programs or the public employee programs.

## MEDICAL EVIDENCE

Labor and delivery typically take place under the care of nurses and doctors who monitor the birthing process and ensure the safety of mother and baby.<sup>i</sup> Labor progresses through three main stages—early labor, active labor, and the transition phase—each defined by changes in the cervix.<sup>ii</sup> The cervix, which connects the uterus to the vagina, begins to efface (thin) and dilate during early labor, causing contractions that last about 30-45 seconds and occur every 5 to 30 minutes.<sup>iii</sup> In active labor, the cervix continues to dilate, and contractions intensify, usually occurring every 3 to 5 minutes. During the transition phase, the cervix reaches full dilation at 10 cm, with contractions peaking at 90 seconds, at intervals ranging from 30 seconds to 2 minutes.<sup>iv</sup>

Expecting families can choose to give birth at home, at a birthing center, or in a hospital. While the American College of Obstetricians and Gynecologists (ACOG) recommends hospitals and accredited birthing centers as the safest settings for childbirth, it also acknowledges a woman's right to make a medically informed decision about where to give birth.<sup>v</sup> Though planned home births carry certain risks, many individuals opt for them to reduce the likelihood of medical interventions such as episiotomies, instrumental vaginal deliveries, and cesarean delivery.<sup>vi,vii</sup> The World Health Organization (WHO) notes that "...increasing medicalization of childbirth processes tends to undermine the woman's own capability to give birth and negatively impacts her childbirth experience."<sup>viii</sup> For some, home birth offers a greater sense of control, comfort, and privacy, as well as advantages like lower costs, immediate bonding with the baby, and reduced rates of maternal morbidity.<sup>ix,x,xi</sup>

However, a major concern with planned home births is the increased risk of infant mortality. According to ACOG, planned home births are associated with "... more than twofold increased risk of perinatal death and a threefold increased risk of neonatal seizures or serious neurologic dysfunction."<sup>xii</sup> These elevated risks are largely due to the lack of immediate access to advanced medical equipment and qualified medical personnel.<sup>xiii</sup> As a result, ACOG advises against planned home birth for individuals with fetal malpresentation, multiple gestation, or a history of cesarean delivery, as these conditions significantly increase the likelihood of complications.<sup>xiv</sup> Although at-home childbirth is generally considered to be safe for "low risk" pregnancies, complications can still occur during any childbirth, including those in which the patient is considered "low risk."<sup>xv</sup> Complications may potentially be exacerbated when they occur under circumstances where there is a delay in the patient accessing appropriate medical interventions.<sup>xvi</sup> Although best practices for planned at-home childbirths include attendance licensed or certified health care professionals with the training and equipment needed to address potential complications and timely access to consultation and safe hospital transfer, the potential for delays in access to needed care may be heightened for at-home births.<sup>xvii</sup>

Improving outcomes for planned home births depends on several key factors: the presence of a certified nurse-midwife (CNM), certified midwife (CM), or physician trained in obstetrics who meets the International Confederation of Midwives' Global Standards; integration within a

regulated healthcare system; and timely access to consultation and safe hospital transfer when necessary.<sup>xviii</sup> In addition, the American Academy of Pediatrics (AAP) and the American Heart Association recommend that home births be attended by two personnel, of whom at least one has the appropriate skills and equipment to perform a full resuscitation of the infant.<sup>xix</sup>

Midwives can play a crucial role in supporting safe childbirth, particularly in home birth settings. CNMs and CMs are highly educated healthcare professionals who provide a wide range of services throughout pregnancy, labor, delivery, and the postpartum period.<sup>xx</sup> They are nationally certified, state-licensed, and often practice in homes, hospitals, birthing centers, and clinics. They are trained to monitor both maternal and fetal health, manage routine aspects of pregnancy and childbirth, prescribe medications, and provide newborn care for the first 28–30 days of life.<sup>xxi</sup> In cases where complications arise, midwives collaborate with or refer patients to obstetricians or other specialists, facilitating a smooth transition of care when higher-level interventions are required.<sup>xxii</sup> According to the American College of Nurse-Midwives, midwives are grounded in the philosophy that childbirth is a normal physiological process and prioritize respectful, evidence-based, and personalized care.<sup>xxiii</sup> The American College of Nurse-Midwives further asserts that the presence of a midwife not only increases safety in out-of-hospital births but also helps build trust, reduce unnecessary medical interventions, and support informed decision-making for families.<sup>xxiv</sup>

Similarly, certified doulas provide support and education to birthing parents and act as their advocates. They are trained care professionals who provide holistic support during pregnancy, birth, and the postpartum period.<sup>xxv</sup> They differ from CNMs in their education. While CNMs have master's degrees and can provide medical services, doulas receive state certifications or participate in training programs.<sup>xxvi</sup>

In New Jersey, the licensure requirements for midwives, certified professional midwives, and CNMs are set forth at N.J.S.A.45:10-1 *et seq.* Although there is no statewide requirement for doula licensure or certification, doulas are required to meet certain requirements to be eligible for reimbursement under Medicaid.<sup>xxvii</sup>

## **SOCIAL IMPACT**

Numerous studies have highlighted the significant cost difference between home and hospital births.<sup>xxviii</sup> On average, a home birth costs approximately \$4,650, while a vaginal hospital birth averages around \$12,235 and a cesarean delivery averages \$17,004.<sup>xxix,xxx</sup> This figure for hospital births is likely an underestimate, as it does not account for more expensive scenarios such as extended hospital stays due to low birth weight or other complications.<sup>xxxi</sup> Although costs vary by state and insurance coverage, national data indicate an average cost difference of approximately \$7,585 between home and hospital vaginal births.<sup>xxxii</sup> However, because these cost estimates may not adjust for acuity, the average cost difference for low-risk births performed in hospitals as compared with at-home settings may potentially be lower than the overall average difference.

When home births are not covered by insurance, the parents may be required to pay out-of-pocket for some or all the costs of the home birth, including the costs of any professionals attending the birth, which may make home birth an unaffordable option for some who would otherwise prefer it to giving birth in a hospital or birthing center. For those who can afford to pay out-of-pocket for a home birth, the cost may reduce available funds that could be put toward other postpartum support services, such as those provided by a postpartum doula, who can assist with lactation support, emotional and physical support, and family support.<sup>xxxiii</sup> Although these services can be beneficial to both the mother and the newborn baby, they have not historically been covered by commercial insurance, although in New Jersey, some are covered under the individual and small employer health benefits programs (where doula coverage is optional at the carrier level and is accommodated by the standardized contracts used in those markets), commercial insurance, the SHBP and SEHBP, and Medicaid.<sup>xxxiv,xxxv,xxxvi</sup>

Maternal morbidity and mortality are significant issues in the United States, both of which disproportionately affect racial and ethnic minorities. In 2023, the U.S. Centers For Disease Control and Prevention (CDC) reported that the maternal mortality rate for Black women was 50.3 deaths per 100,000 live births, compared with 14.5 among White women, 12.4 for Hispanic women, and 10.7 for Asian women.<sup>xxxvii</sup> In addition to higher mortality, Black women are five times more likely than White women to experience severe maternal morbidity, including preventable complications such as eclampsia, preeclampsia, and postpartum cardiomyopathy.<sup>xxxviii,xxxix</sup> These inequities persist even when controlling for differences in income and education.<sup>xl</sup>

A possible contributing factor to the disproportionate rate of maternal mortality in the United States is the limited availability of maternity care providers, particularly CNMs.<sup>xli</sup> Numerous counties throughout the United States lack practicing obstetrician-gynecologists, and more than half do not have CNMs at all.<sup>xlii</sup> One study looked at the integration of midwives into regional health systems across the United States to compare the rates of maternal-newborn outcomes.<sup>xliii</sup> Application of the Midwifery Integration Scoring System (MISS) demonstrated that higher scores were significantly associated with increased rates of spontaneous vaginal delivery, vaginal birth after cesarean, and breastfeeding, and decreased rates of cesarean delivery, preterm birth, low birth weight, and neonatal death.<sup>xliv</sup>

Another study looked at the mistreatment of women from different racial and ethnic backgrounds while considering place of birth. The study found that higher rates of mistreatment, including the women being ignored, being subjected to verbal abuse, and receiving no response to requests for help, occurred in hospitals (28.1%) compared with home births (5.1%) and freestanding birthing centers (7%).<sup>xlv</sup> These findings are particularly relevant for Black, Indigenous, and Hispanic women, who experience the highest rates of mistreatment in hospital settings: 32.8% among Indigenous women, 25% among Hispanic women, and 22.5% among Black women.<sup>xlvi</sup> The authors of the study suggest that childbirth location could have a modulating effect on

mistreatment regardless of racial and ethnic background, as mistreatment was less frequently reported in out-of-hospital birth settings.<sup>xlvii</sup>

A study published by the American Journal of Obstetrics & Gynecology describes the midwifery model of care as a relationship-centered approach that emphasizes trust and creates environments that “feel nonthreatening and comfortable for the childbearing person.”<sup>xlviii</sup> The study further found that mistreatment is less likely to happen in community birth settings (*i.e.* at home or in a birthing center).<sup>xlix</sup> However, as described above, ACOG recommends the appropriate selection of licensed or certified health care professionals to support planned home births and to promote safety for both mothers and infants.<sup>1</sup>

## OTHER STATES

Five states currently mandate insurance coverage for home childbirth: Illinois, New Hampshire, New Mexico, and Vermont mandate coverage by statute, while New York’s coverage mandate was established pursuant to a legal opinion.

In 2008, New Hampshire amended existing law, at RSA 415:6-1, to expressly require health insurance coverage for certified midwife services provided at home: “Each insurer...shall...provide coverage...for services rendered by a midwife...contingent upon services being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.”<sup>li</sup> The law further specifies that the services may not be subject to any greater cost sharing than applies to similar benefits under the plan.

Similarly, in 2011, Vermont enacted 8 V.S.A. s.4078, which requires health insurance plans and health benefit plans that provide maternity benefits to cover services rendered by a licensed midwife or an advanced practice registered nurse certified as a nurse midwife “for services within the licensed midwife’s or certified nurse midwife’s scope of practice and provided in a hospital or other health care facility or at home.”<sup>lii</sup> The law further specifies that the services may not be subject to any greater cost sharing than applies to similar benefits under the plan.<sup>liii</sup>

In 2006, New Mexico established the Birthing Options Program (BOP) under its Medicaid program, which provides coverage for certain midwife services provided in out-of-hospital settings, including at home.<sup>liv</sup> BOP services cover prenatal care and labor and delivery for low-risk or uncomplicated pregnancies and childbirth. In New Mexico, roughly 26 percent of all births are attended by midwives, while the national average is closer to 10 percent.<sup>lv</sup> A study of the BOP’s impact suggests, “New Mexico’s high utilization of midwives may contribute to the state’s above average birth outcomes.”<sup>lvi</sup> These outcomes include a higher rate of spontaneous vaginal deliveries and a lower rate of caesarean deliveries than the national average, as well as increased rates of breastfeeding at birth and reduced rates of premature deliveries and low birth weights.

New Mexico’s insurance code, as stated in New Mexico Statute 59A-47-28.1, requires commercial coverage for “obstetrical and/or maternity...services of a certified nurse-midwife or registered lay midwife...”<sup>lvii</sup> That statute continues, “Deductibles, limits of coverage or other terms and conditions of coverage for such services shall not differ substantially from coverage for the same or similar services provided by other practitioners.”<sup>lviii</sup> Midwifery services for home births are reimbursed by commercial payers.

Illinois Public Act 103-0720, which was signed into law on July 29, 2024,<sup>lix</sup> amended the state’s Insurance Code to require that, “Insurers shall cover all services...rendered by perinatal doulas or licensed certified professional midwives, including home births...”<sup>lx</sup>

In addition to Illinois, several other states (Rhode Island, Louisiana, Colorado, Delaware, and Virginia) enacted laws that require commercial insurers to cover the services of doulas; however, Illinois is the only state to include explicit language ensuring that such coverage includes home births. Louisiana’s law “allows insurers to impose a per-pregnancy limit of \$1,500.”<sup>lxi</sup> Colorado, Virginia, and Delaware are in the process of implementing their doula care coverage laws.<sup>lxii</sup>

In 2000, New York’s Insurance Law, Article 43, was amended to require coverage for midwife services. On April 13, 2005, New York’s Office of the General Counsel (NYOGC) offered its opinion, representing the position of the New York State Insurance Department, in response to the question: “Must health insurance policies cover maternity care provided by a midwife?”<sup>lxiii</sup> The NYOGC determined, “The services of a nurse midwife must be covered by a health insurer, including a Health Maintenance Organization.”<sup>lxiv</sup> Furthermore, the NYOGC determined “While home births are not specifically mentioned in New York Insurance Law §4303(c)(1), if supervision of a home birth is within the scope of practice of a midwife, the HMO would have to provide coverage for such services.”<sup>lxv</sup> That opinion was codified in New York’s 2006 Insurance Law, Article 43, section 4303 (c), which reads, “[C]overage for maternity care shall include the services of a midwife...”<sup>lxvi</sup>

In New York, HMOs and Managed Care Organizations (MCOs) are also required to contract with licensed midwives,<sup>lxvii</sup> as reflected in New York Codes, Rules and Regulations, Title 10, Part 98.<sup>lxviii</sup> A 2025 New York Department of Health update on MCO guidelines also lists “Nurse Midwife/Certified Midwife” as a mandatory category in a table containing required providers in MCO delivery networks.<sup>lxix</sup>

In summary, New Hampshire, Vermont, and Illinois have enacted laws expressly requiring commercial insurers to provide coverage for home births attended by accredited midwives. Illinois’ law also mandates that commercial insurers cover services, including home births, provided by accredited doulas. New Mexico has a statutory requirement that midwife services be covered by insurance, and has additionally established an out-of-hospital Birth Options Program in Medicaid that provides at least partial coverage for midwife services that are provided in non-hospital settings. New York has specified that its insurance coverage laws apply to midwife

services in connection with home births. Commercial insurance coverage for care provided by accredited doulas is also mandated by the enacted laws of Rhode Island and Louisiana; such coverage will also soon be mandated by the enacted laws of Colorado, Virginia, and Delaware. While these state doula laws do not specify that such coverage must apply to home births, these coverage mandates may potentially be read to apply to home births, as well as hospital and facility births.

## **DISCUSSION**

Studies indicate that for low-risk pregnancies home births represent a comparatively safe alternative to hospital and birthing center deliveries, with lower likelihoods of medical interventions. The elevated risks of fetal mortality and morbidity associated with home births can be mitigated to some extent by assuring that home birth care teams include individuals with the advanced training and equipment needed to address emergency situations. Risks can also be lowered by assuring that home birthing plans include a contingency for transferring the woman to hospital care if emergent delivery situations require specialized attention.

Home births for low-risk pregnancies also represent a much lower cost alternative to deliveries in birthing centers or hospitals. As discussed above, the national difference between the cost of a vaginal birth in a hospital and a vaginal birth at home is approximately \$7,585. The difference in cost between an average birth in a birthing center and a home birth is estimated at \$3,659.<sup>lxx</sup> One study of births in the United States estimated that “each shift of one percent of births from hospitals to homes would represent an annual cost savings to society of at least USD 321 million.”<sup>lxxi</sup> That study concluded that with costs divided among “public assistance programs, employer-funded insurers, family-funded insurers, and families paying out-of-pocket...home births represent[s] an opportunity for substantial savings for governments, employers, insurance providers, and households.”<sup>lxxii</sup> In particular, a coverage mandate for home births would reduce out-of-pocket costs for individuals who choose home birth but lack insurance coverage for the home birth.

A coverage mandate may help promote access to home birth for women seeking an alternative to giving birth in a hospital or other facility, and studies suggest that increased access to home births may also help reduce racial and ethnic disparities in health care outcomes and adverse incidents, to the extent those are affiliated with facility-based births.

Although mandatory insurance coverage may promote access to home birth while reducing costs overall, it has been noted that potential limits in the availability of maternity care providers may limit the scope and effect of the mandate, particularly to the extent that the number of midwives, licensed professional midwives, and CNMs is outpaced by demand for services. A coverage mandate for home births could potentially exacerbate workforce shortages, although, assuming the mandate for home birth would not affect the overall birth rate in New Jersey, it may be the case that a coverage mandate would result in a shift in the proportion of services provided in facilities

as compared with out-of-hospital settings. It is also possible that a coverage mandate for home birth would foster an increase in the maternity care workforce.

## FINANCIAL IMPACT

There is limited information on the financial impact on states of legislation requiring that commercial insurers cover home births or extend commercial insurance coverage to doula care. New Jersey produced a fiscal estimate on the impact of its home birth bill and Louisiana produced a fiscal note on the estimated impact of its doula care bill. However, the estimates of the bills' impacts on state budgets in these analyses is limited.

New Jersey's Office of Legislative Services (OLS) prepared a Legislative Fiscal Estimate for S1097 (SCS), the companion bill to A5609. The OLS advised that since current state health benefits programs already cover home childbirth services billed by an eligible provider, any change in government expenditures would be the result of extending coverage to services provided by doulas irrespective of the delivery setting.<sup>lxxiii</sup> The OLS estimated that the bill "will annually increase combined State and local government expenditures by \$3,400 by requiring the State Health Benefits Program and School Employees' Health Benefits Program to provide coverage for doula services associated with home childbirths." The OLS also estimated that "annual State costs associated with the State Medicaid program...may potentially decrease by an indeterminate amount because of the potentially lower costs for home childbirths...compared...with a hospital birth."<sup>lxxiv</sup> The OLS Fiscal Estimate does not measure the cost impact to the commercial markets; by statute, OLS Fiscal Estimates are limited to reviewing the potential cost implications of pending legislation on State and local governments.

Louisiana's Office of Group Benefits (OGB) produced a Fiscal Note estimating the impact of its law requiring commercial insurers to cover services provided by a doula. The OGB divided the analysis into two parts: insurance coverage provided under the five self-funded plans of the OGB, and the commercial plans available on Louisiana's insurance exchanges.<sup>lxxv</sup> The OGB carries a large reserve balance (as of February 2023, that balance was \$434 million); the analysis assumed that the costs of the new mandate to the self-funded plans would be paid from the OGB reserve fund. Any shortfall would be paid by the State General Fund. The annual fiscal year cost estimate of the mandate for FY 2024-2025, the first full year of the doula care requirement, ranged from a low of \$63,534 to a high of \$196,310. Over four-and-a-half fiscal years, the total cost of the mandate ranged from an estimated low of \$300,339 to a high of \$928,001.<sup>lxxvi</sup> The OGB explained, "The Office of Group Benefits (OGB) does not anticipate the proposed law to require premium increases...."<sup>lxxvii</sup>

OGB's analysis also extended to the commercial plans offered on Louisiana's insurance exchanges. The estimated cost of the new mandate to providers for the first full fiscal year ranged from a low of \$46,656 to a high of \$124,416, and for the fourth full fiscal year the cost estimates

ranged from a low of \$54,101 to a high of \$144,027.<sup>lxxviii</sup> These costs would be paid by the State General Fund. The OGB estimated commercial plan premiums would rise between \$0.03 per member per month (PMPM) and \$0.08 PMPM over the entire insured population with the enactment of the doula insurance mandate.<sup>lxxix</sup>

Another consideration is that the bill would require coverage for the “costs associated with planned home childbirth, including, but not limited to, services provided by a health care provider, services provided by a doula, and equipment and medical supplies.” Although the language includes examples of what would be encompassed by this requirement, there is the potential that “costs associated” could be read to require coverage for equipment, supplies, or services that are not ordinarily covered under a contract, which could potentially affect the cost of the mandate, particularly where a plan does not have prices or network agreements in place for that equipment, supply, or service.

An additional consideration is that the federal Patient Protection and Affordable Care Act requires states to defray the cost of any health insurance benefit mandate enacted after December 31, 2011, that is part of an insurance plan sold on a state exchange that is in addition to the state’s essential health benefits (EHBs) and related to specific care, treatment, or services (P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170). The State must then defray the cost of the additional mandates by making the appropriate payment directly to an enrollee or to the insurer on the enrollee’s behalf (45 CFR 155.170). A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state’s exchange to the state. Defrayment does not apply to the large group market. For more information on State-required benefits, please refer to this CMS FAQ on Defrayal of State Additional Required Benefits.<sup>lxxx</sup> As part of the HHS Notice of Benefit and Payment Parameters for 2025, for plan years beginning on or after January 1, 2027, CMS revised the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process.<sup>lxxxi</sup> The process of updating the state’s EHB-benchmark plan could create a pathway to adding benefits to the benchmark plan that may not trigger defrayal, provided certain parameters are met. Thus, although this would require a state-by-state analysis and no such analysis has been performed for New Jersey, a mandate that requires health insurance coverage for planned home childbirth may trigger the federal defrayment requirements.

## CONCLUSION

A5609 would require health insurance coverage for planned home births and any associated costs including services provided by a healthcare provider, services provided by a doula, and equipment and medical supplies. Comprehensive coverage requirements for planned home births are not common, and there is an ongoing debate within the medical community concerning the risks and benefits of home birth. According to the ACOG, planned home births are associated with a more

than twofold increase in the risk of perinatal death and with a threefold increase in the risk of neonatal seizures or serious neurologic impairment. However, ACOG also recognizes that fewer maternal interventions occur in home birth settings, which may make home birth more appealing to women than giving birth in a hospital, despite the risks. If a woman chooses to have a home birth after being informed of risks and benefits, the ACOG recommends: 1) that appropriate healthcare providers are present, such as a CNM; 2) that there is ready access to medical consultation; and 3) that there is access to reliable and timely transportation to a nearby hospital in the event of more serious or complex complications.

Studies have shown that, despite the risks attendant to home births, pregnancies that are considered low risk are generally safe to deliver at home. For some families, home births provide comfort and control, as well as the opportunity to have a labor experience with less medical intervention. Home births follow the midwife model of care, which studies suggest reduces birth injury, trauma, and cesarean deliveries by providing individualized attention to each mother. This model of care becomes more significant when considering that minority women giving birth in hospitals experience higher rates of maternal morbidity and mistreatment when compared to White women. Increased access to home birth resulting from a coverage mandate may make the benefits of home birth accessible to additional families while helping to reduce racial disparities in maternal morbidity and mistreatment.

Several states have enacted statutes requiring commercial insurance coverage for home birth services, though each state defines its coverage differently. New York, New Hampshire, Vermont, and Illinois mandate coverage for home births attended by certified midwives, with Illinois additionally requiring coverage for accredited doulas. Rhode Island and Louisiana have also implemented legislation requiring commercial insurers to cover doula services, with Colorado, Virginia, and Delaware expected to soon implement similar mandates.

To the extent that A5609 would expand mandatory coverage to include doula services, there would likely be an increased cost to carriers, which could result in increased premiums for consumers. However, to the extent that mandatory coverage for home births could increase homebirth rates, which are generally less costly than hospital births, carriers could see reduced costs, which may offset any increased costs for doula services and potentially result in lower premiums overall. One factor affecting this analysis is the extent to which carriers are currently providing coverage for home births. Increased utilization of home birth may also increase demand for certain maternal care professionals, particularly midwives, but the effects of this may be reduced to the extent the existing workforce is simply shifting the site of care. It is not possible to reliably estimate the effects the bill would have on workforce availability or carrier costs.

## ENDNOTES

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<sup>i</sup> NYU Langone Health, “Labor & Delivery,” 2025. Accessed 9/10/25. [Vaginal Birth | NYU Langone Health](#)

<sup>ii</sup> *Ibid.*

<sup>iii</sup> *Ibid.*

<sup>iv</sup> *Ibid.*

<sup>v</sup> American College of Obstetricians & Gynecologists (ACOG), “Planned Home Birth,” April 2017. Accessed 9/10/25. [Planned Home Birth | ACOG](#)

<sup>vi</sup> Mayo Clinic, “Home Birth: Know the Pros and Cons,” March 12, 2025. Accessed 9/11/25. [Home birth: Know the pros and cons - Mayo Clinic](#)

<sup>vii</sup> Zielinski, Ruth, Ackerson, Kelly, and Low, Lisa, K., “Planned Home Births: Benefits, Risks, and Opportunities,” *International Journal of Women’s Health*, 7, 361-377, April 8, 2015. Accessed 9/11/25. [Planned home birth: benefits, risks, and opportunities - PMC](#)

<sup>viii</sup> World Health Organization (WHO), “WHO Recommendations Intrapartum, Care for a Positive Childbirth Experience,” 2018. Accessed 9/15/25. [WHO](#)

<sup>ix</sup> Mayo Clinic, *op cit.*

<sup>x</sup> American Pregnancy Association, “Home Births,” 2025. Accessed 9/15/25. [Home Births | American Pregnancy Association](#)

<sup>xi</sup> Zielinski, *op cit.*

<sup>xii</sup> ACOG, *op cit.*

<sup>xiii</sup> Marygrace Taylor, “A Mom’s Guide to a Hospital Birth,” July 7, 2023. Accessed 9/16/25. [A Mom's Guide to a Hospital Birth](#)

<sup>xiv</sup> ACOG, *op cit.*

<sup>xv</sup> Danilack, Valery, A., Nunes, Anthony, P., and Phipps, Maureen, G., “Unexpected Complications of Low-risk Pregnancies in the United States,” *American Journal of Obstetrics and Gynecology*, 212(6), June 2015. Accessed 1/30/26. [Unexpected complications of low-risk pregnancies in the United States - PubMed](#)

<sup>xvi</sup> *Ibid.*

<sup>xvii</sup> ACOG, *op cit.*

<sup>xviii</sup> *Ibid.*

<sup>xix</sup> Watterberg, Kristi, L., Papile, Lu-Ann, Baley, Jill, E., Benitz, William, *et al.*, “Planned Home Birth,” *Pediatrics*, 131(5), May 2013. Accessed 9/17/25. [Planned Home Birth | Pediatrics | American Academy of Pediatrics](#)

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<sup>xx</sup> American College of Nurse-Midwives, "What Is a Midwife?," *Journal of Midwifery & Women's Health*, 68(3), May 31, 2023. Accessed 9/16/25. [What is a Midwife?](#)

<sup>xxi</sup> *Ibid.*

<sup>xxii</sup> *Ibid.*

<sup>xxiii</sup> *Ibid.*

<sup>xxiv</sup> *Ibid.*

<sup>xxv</sup> Cleveland Clinic, "Nurse Midwife vs. Doula: Who Does What?," February 12, 2024. [Difference Between a Doula and a Nurse Midwife](#)

<sup>xxvi</sup> *Ibid.*

<sup>xxvii</sup> New Jersey Department of Health, "How to Become a NJ FamilyCare Community Doula Provider," 2025. Accessed 12/12/2025. <https://www.nj.gov/health/doulas/how-to-become-a-nj-familycare-doula-provider/>

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# ASSEMBLY, No. 5609

## STATE OF NEW JERSEY

### 221st LEGISLATURE

INTRODUCED MAY 5, 2025

**Sponsored by:**

**Assemblywoman SHANIQUE SPEIGHT**

**District 29 (Essex and Hudson)**

**Assemblywoman CARMEN THERESA MORALES**

**District 34 (Essex)**

**SYNOPSIS**

Requires health insurance carriers and Medicaid to provide coverage for planned home childbirth.

**CURRENT VERSION OF TEXT**

As introduced.



(Sponsorship Updated As Of: 5/5/2025)

1 AN ACT concerning health insurance coverage of planned home  
2 childbirth and supplementing various parts of the statutory law.

3

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

6

7 1. a. A hospital service corporation contract that provides  
8 hospital and medical expense benefits and is delivered, issued,  
9 executed or renewed in this State pursuant to P.L.1938, c.366  
10 (C.17:48-1 et seq.), or approved for issuance or renewal in this State  
11 by the Commissioner of Banking and Insurance, on or after the  
12 effective date of this act, shall provide coverage for costs associated  
13 with planned home childbirth, including, but not limited to, services  
14 provided by a health care provider, services provided by a doula,  
15 and equipment and medical supplies.

16 b. The coverage shall be provided to the same extent as for any  
17 other health care services under the hospital service corporation  
18 contract.

19 c. This section shall apply to those hospital service corporation  
20 contracts in which the hospital service corporation has reserved the  
21 right to change the premium.

22 d. As used in this section, "health care provider" means an  
23 individual or entity which, acting within the scope of its licensure  
24 or certification, provides health care services. "Health care  
25 provider" includes a family practice physician, obstetrician,  
26 advanced practice nurse, registered professional nurse, licensed  
27 practical nurse, certified professional midwife, certified nurse  
28 midwife, or certified midwife.

29

30 2. a. A medical service corporation contract that provides  
31 hospital and medical expense benefits and is delivered, issued,  
32 executed or renewed in this State pursuant to P.L.1940, c.74  
33 (C.17:48A-1 et seq.), or approved for issuance or renewal in this  
34 State by the Commissioner of Banking and Insurance, on or after  
35 the effective date of this act, shall provide coverage for costs  
36 associated with planned home childbirth, including, but not limited  
37 to, services provided by a health care provider, services provided by  
38 a doula, and equipment and medical supplies.

39 b. The coverage shall be provided to the same extent as for any  
40 other health care services under the medical service corporation  
41 contract.

42 c. This section shall apply to those medical service corporation  
43 contracts in which the medical service corporation has reserved the  
44 right to change the premium.

45 d. As used in this section, "health care provider" means an  
46 individual or entity which, acting within the scope of its licensure  
47 or certification, provides health care services. "Health care  
48 provider" includes a family practice physician, obstetrician,

1 advanced practice nurse, registered professional nurse, licensed  
2 practical nurse, certified professional midwife, certified nurse  
3 midwife, or certified midwife.

4

5 3. a. A health service corporation contract that provides  
6 hospital and medical expense benefits and is delivered, issued,  
7 executed or renewed in this State pursuant to P.L.1985, c.236  
8 (C.17:48E-1 et seq.), or approved for issuance or renewal in this  
9 State by the Commissioner of Banking and Insurance, on or after  
10 the effective date of this act, shall provide coverage for costs  
11 associated with planned home childbirth, including, but not limited  
12 to, services provided by a health care provider, services provided by  
13 a doula, and equipment and medical supplies.

14 b. The coverage shall be provided to the same extent as for any  
15 other health care services under the health service corporation  
16 contract.

17 c. This section shall apply to those health service corporation  
18 contracts in which the health service corporation has reserved the  
19 right to change the premium.

20 d. As used in this section, "health care provider" means an  
21 individual or entity which, acting within the scope of its licensure  
22 or certification, provides health care services. "Health care  
23 provider" includes a family practice physician, obstetrician,  
24 advanced practice nurse, registered professional nurse, licensed  
25 practical nurse, certified professional midwife, certified nurse  
26 midwife, or certified midwife.

27

28 4. a. An individual health insurance policy that provides  
29 hospital and medical expense benefits and is delivered, issued,  
30 executed or renewed in this State pursuant to N.J.S.17B:26-1 et  
31 seq., or approved for issuance or renewal in this State by the  
32 Commissioner of Banking and Insurance, on or after the effective  
33 date of this act, shall provide coverage for costs associated with  
34 planned home childbirth, including, but not limited to, services  
35 provided by a health care provider, services provided by a doula,  
36 and equipment and medical supplies.

37 b. The coverage shall be provided to the same extent as for any  
38 other health care services under the policy.

39 c. This section shall apply to those individual health insurance  
40 policies in which the insurer has reserved the right to change the  
41 premium.

42 d. As used in this section, "health care provider" means an  
43 individual or entity which, acting within the scope of its licensure  
44 or certification, provides health care services. "Health care  
45 provider" includes a family practice physician, obstetrician,  
46 advanced practice nurse, registered professional nurse, licensed  
47 practical nurse, certified professional midwife, certified nurse  
48 midwife, or certified midwife.

1       5. a. A group health insurance policy that provides hospital  
2 and medical expense benefits and is delivered, issued, executed or  
3 renewed in this State pursuant to N.J.S.17B:27-26 et seq., or  
4 approved for issuance or renewal in this State by the Commissioner  
5 of Banking and Insurance, on or after the effective date of this act,  
6 shall provide coverage for costs associated with planned home  
7 childbirth, including, but not limited to, services provided by a  
8 health care provider, services provided by a doula, and equipment  
9 and medical supplies.

10       b. The coverage shall be provided to the same extent as for any  
11 other health care services under the policy.

12       c. This section shall apply to those group health insurance  
13 policies in which the insurer has reserved the right to change the  
14 premium.

15       d. As used in this section, “health care provider” means an  
16 individual or entity which, acting within the scope of its licensure  
17 or certification, provides health care services. “Health care  
18 provider” includes a family practice physician, obstetrician,  
19 advanced practice nurse, registered professional nurse, licensed  
20 practical nurse, certified professional midwife, certified nurse  
21 midwife, or certified midwife.

22  
23       6. a. A health maintenance organization contract for health  
24 care services that is delivered, issued, executed, or renewed in this  
25 State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved  
26 for issuance or renewal in this State by the Commissioner of  
27 Banking and Insurance, on or after the effective date of this act,  
28 shall provide coverage for costs associated with planned home  
29 childbirth, including, but not limited to, services provided by a  
30 health care provider, services provided by a doula, and equipment  
31 and medical supplies.

32       b. The coverage shall be provided to the same extent as for any  
33 other health care services under the contract.

34       c. This section shall apply to those policies in which the health  
35 maintenance organization has reserved the right to change the  
36 schedule of charges for enrollee coverage.

37       d. As used in this section, “health care provider” means an  
38 individual or entity which, acting within the scope of its licensure  
39 or certification, provides health care services. “Health care  
40 provider” includes a family practice physician, obstetrician,  
41 advanced practice nurse, registered professional nurse, licensed  
42 practical nurse, certified professional midwife, certified nurse  
43 midwife, or certified midwife.

44  
45       7. a. An individual health benefits plan that provides hospital  
46 and medical expense benefits and is delivered, issued, executed or  
47 renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et  
48 seq.), or approved for issuance or renewal in this State by the

1 Commissioner of Banking and Insurance, on or after the effective  
2 date of this act, shall provide coverage for costs associated with  
3 planned home childbirth, including, but not limited to, services  
4 provided by a health care provider, services provided by a doula,  
5 and equipment and medical supplies.

6 b. The coverage shall be provided to the same extent as for any  
7 other health care services under the health benefits plan.

8 c. This section shall apply to those health benefits plans in  
9 which the carrier has reserved the right to change the premium.

10 d. As used in this section, "health care provider" means an  
11 individual or entity which, acting within the scope of its licensure  
12 or certification, provides health care services. "Health care  
13 provider" includes a family practice physician, obstetrician,  
14 advanced practice nurse, registered professional nurse, licensed  
15 practical nurse, certified professional midwife, certified nurse  
16 midwife, or certified midwife.

17

18 8. a. A small employer health benefits plan that provides  
19 hospital and medical expense benefits and is delivered, issued,  
20 executed or renewed in this State pursuant to P.L.1992, c.162  
21 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this  
22 State by the Commissioner of Banking and Insurance, on or after  
23 the effective date of this act, shall provide coverage for costs  
24 associated with planned home childbirth, including, but not limited  
25 to, services provided by a health care provider, services provided by  
26 a doula, and equipment and medical supplies.

27 b. The coverage shall be provided to the same extent as for any  
28 other health care services under the health benefits plan.

29 c. This section shall apply to those policies in which the carrier  
30 has reserved the right to change the premium.

31 d. As used in this section, "health care provider" means an  
32 individual or entity which, acting within the scope of its licensure  
33 or certification, provides health care services. "Health care  
34 provider" includes a family practice physician, obstetrician,  
35 advanced practice nurse, registered professional nurse, licensed  
36 practical nurse, certified professional midwife, certified nurse  
37 midwife, or certified midwife.

38

39 9. a. The State Health Benefits Commission, on or after the  
40 effective date of this act, shall provide coverage for costs associated  
41 with planned home childbirth, including, but not limited to, services  
42 provided by a health care provider, services provided by a doula,  
43 and equipment and medical supplies.

44 b. The coverage shall be provided to the same extent as for any  
45 other health care services under the contract.

46 c. As used in this section, "health care provider" means an  
47 individual or entity which, acting within the scope of its licensure  
48 or certification, provides health care services. "Health care

1 provider” includes a family practice physician, obstetrician,  
2 advanced practice nurse, registered professional nurse, licensed  
3 practical nurse, certified professional midwife, certified nurse  
4 midwife, or certified midwife.

5

6 10. a. The School Employees’ Health Benefits Commission on  
7 or after the effective date of this act, shall provide coverage for  
8 costs associated with planned home childbirth, including, but not  
9 limited to, services provided by a health care provider, services  
10 provided by a doula, and equipment and medical supplies.

11 b. The coverage shall be provided to the same extent as for any  
12 other health care services under the contract.

13 c. As used in this section, “health care provider” means an  
14 individual or entity which, acting within the scope of its licensure  
15 or certification, provides health care services. “Health care  
16 provider” includes a family practice physician, obstetrician,  
17 advanced practice nurse, registered professional nurse, licensed  
18 practical nurse, certified professional midwife, certified nurse  
19 midwife, or certified midwife.

20

21 11. a. Notwithstanding the provisions of any State law or  
22 regulation to the contrary, the Division of Medical Assistance and  
23 Health Services in the Department of Human Services, or a  
24 managed care organization contracted with the division to provide  
25 benefits under NJ FamilyCare, shall cover the costs incurred for a  
26 planned home childbirth, including, but not limited to, services  
27 provided by a health care provider, services provided by a doula,  
28 and equipment and medical supplies, when the services are  
29 provided to a beneficiary of NJ FamilyCare by an in-network health  
30 care provider.

31 b. The Commissioner of Human Services shall apply for such  
32 State plan amendments or waivers as may be necessary to  
33 implement the provisions of this section and to secure federal  
34 financial participation for NJ FamilyCare expenditures under the  
35 Medicaid program and Children’s Health Insurance Program.

36 c. The department may take any administrative action  
37 necessary to effectuate the provisions of this section, including  
38 modifying or amending any applicable contract or promulgating,  
39 amending, or repealing any guidance, guidelines, or rules, which  
40 rules or amendments thereto shall be effective immediately upon  
41 filing with the Office of Administrative Law for a period not to  
42 exceed 12 months, and may, thereafter, be amended, adopted or  
43 readopted in accordance with the provisions of the “Administrative  
44 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.).

45 d. As used in this section:

46 “Health care provider” means an individual or entity which,  
47 acting within the scope of its licensure or certification, provides  
48 health care services. “Health care provider” includes a family

1 practice physician, obstetrician, advanced practice nurse, registered  
2 professional nurse, licensed practical nurse, certified professional  
3 midwife, certified nurse midwife, or certified midwife.

4 “NJ FamilyCare” means the program established pursuant to  
5 P.L.2005, c.156 (C.30:4J-8 et al.), which includes the Medicaid  
6 program and the Children’s Health Insurance Program.

7

8 12. Sections 1 through 10 of this act shall take effect on the  
9 120th day following enactment, and shall apply to all contracts  
10 delivered, issued, executed or renewed in this State, or approved for  
11 issuance or renewal in this State by the Commissioner of Banking  
12 and Insurance, on or after the effective date of this act. Section 11  
13 of this act shall take effect two years following enactment.

14

15

16 STATEMENT

17

18 This bill requires health insurance carriers (health, hospital and  
19 medical service corporations, health maintenance organizations, and  
20 insurance companies), the State Health Benefits Program, the  
21 School Employees’ Health Benefits Program, and the State  
22 Medicaid and NJ FamilyCare programs to provide coverage for  
23 expenses incurred in planned home childbirth. The required  
24 coverage is to include, but not be limited to, costs associated with  
25 services provided by a health care provider, services provided by a  
26 doula, and equipment and medical supplies.

27 Under the bill, a “health care provider” is defined to mean an  
28 individual or entity which, acting within the scope of its licensure  
29 or certification, provides health care services. The term includes a  
30 family practice physician, obstetrician, advanced practice nurse,  
31 registered professional nurse, licensed practical nurse, certified  
32 professional midwife, certified nurse midwife, or certified midwife.



**NEW JERSEY GENERAL ASSEMBLY**

**ROY FREIMAN**

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**COMMITTEES**  
CHAIR, FINANCIAL INSTITUTIONS AND  
INSURANCE  
VICE CHAIR, OVERSIGHT, REFORM AND  
FEDERAL RELATIONS  
BUDGET

June 12, 2025

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

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institutions and Insurance Committee, I respectfully request the Commission review and prepare a written report of A5609, which requires health insurance carriers and Medicaid to provide coverage for planned home childbirth.

If you have any questions, please do not hesitate to contact Mark Iaconelli, Jr., Esq., Deputy General Counsel, at 609-847-3500.

Thank you for your immediate attention to this matter.

Sincerely,

A handwritten signature in cursive script, appearing to read "Roy Freiman".

CC: Mark Iaconelli, Jr., Esq.  
Deputy General Counsel  
Assembly Majority Office