HOUSE BILL 89

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

INTRODUCED BY

Deborah A. Armstrong

AN ACT

RELATING TO HEALTH COVERAGE FOR CONTRACEPTION; AMENDING THE HEALTH CARE PURCHASING ACT AND ENACTING AND AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE AND THE HEALTH MAINTENANCE ORGANIZATION LAW TO PROVIDE COVERAGE FOR CONTRACEPTION; ENACTING A NEW SECTION OF THE NONPROFIT HEALTH CARE PLAN LAW TO PROVIDE COVERAGE FOR CONTRACEPTION; ENACTING A NEW SECTION OF THE PUBLIC ASSISTANCE ACT TO ESTABLISH DISPENSING REQUIREMENTS; PROVIDING FOR A CONTINGENT REPEAL.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] COVERAGE FOR CONTRACEPTION.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health

Care Purchasing Act that provides coverage for prescription drugs shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) enrollee cost sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

(4) any other restrictions or delays on the coverage.

C. A group health plan may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name

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drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an enrollee's health care provider determines that a particular drug or item is medically necessary, the group health plan shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. A group health plan administrator shall grant an enrollee an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an enrollee, the enrollee's representative or the enrollee's health care provider;

(2) defer to the determination of the enrollee's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

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E. A group health plan shall not require a prescription for any drug, item or service that is available without a prescription.

F. A group health plan shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit a group health plan to limit coverage or impose cost sharing for an alternate method of contraception if an enrollee changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply to short-term travel, accident-only, limited or disease-specific group health plans.

I. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral

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contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional method categories of contraception approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an enrollee is required to pay in accordance with the terms of a group health plan; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business."

SECTION 2. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] MEDICAL ASSISTANCE--REIMBURSEMENT FOR A ONE-YEAR SUPPLY OF COVERED PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

A. In providing coverage for family planning services and supplies under the medical assistance program, the department shall ensure that a recipient is permitted to fill or refill a prescription for a one-year supply of a covered, self-administered contraceptive at one time, as prescribed.

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B. Nothing in this section shall be construed to limit a recipient's freedom to choose or change the method of family planning to be used, regardless of whether the recipient has exhausted a previously dispensed supply of contraceptives."

SECTION 3. Section 59A-22-42 NMSA 1978 (being Laws 2001, Chapter 14, Section 1, as amended) is amended to read:

"59A-22-42. COVERAGE FOR PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, [~~coverage for prescription contraceptive drugs or devices approved by the food and drug administration~~] at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education,

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counseling, device insertion and removal, follow-up care and side-effects management.

B. [~~Coverage for food and drug administration-approved prescription contraceptive drugs or devices may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate~~] Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for insureds;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any other restrictions or delays on the coverage.

C. An insurer may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an insured's health care provider determines that a particular drug or item is medically necessary, the individual or group health insurance policy, health care plan or certificate of insurance shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side

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effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An insurer shall grant an insured an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an insured, the insured's representative or the insured's health care provider;

(2) defer to the determination of the insured's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An insurer shall not require a prescription for any drug, item or service that is available without a prescription.

F. An insurer shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed and self-administered.

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G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an insurer to limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply.

[~~C.~~] H. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified-disease policies.

I. The provisions of this section apply to individual and group health insurance policies, health care plans and certificates of insurance delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate;

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levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an insured is required to pay in accordance with the terms of an individual or group health insurance policy, health care plan or certificate of insurance; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

[~~D.~~] K. A religious entity purchasing individual or group health insurance coverage may elect to exclude prescription contraceptive drugs or devices from the health coverage purchased."

SECTION 4. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE EXCLUSION.--Coverage of vasectomy and male condoms pursuant to Section 3 of this 2019 act is excluded for high-deductible individual and group health insurance policies, health care plans or certificates of insurance with health savings accounts delivered or issued for delivery in this state until an insured's deductible has been

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met."

SECTION 5. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR CONTRACEPTION.--

A. Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for insureds;

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(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any restrictions or delays on the coverage.

C. An insurer may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method category of contraception without cost sharing by the insured; provided that when an insured's health care provider determines that a particular drug or item is medically necessary, the individual or group health insurance policy, health care plan or certificate of health insurance shall cover the brand-name pharmacy drug or item without cost sharing. A determination of medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An insurer shall grant an insured an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an insured,

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the insured's representative or the insured's health care provider;

(2) defer to the determination of the insured's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An insurer shall not require a prescription for any drug, item or service that is available without a prescription.

F. An individual or group health insurance policy, health care plan or certificate of health insurance shall provide coverage and shall reimburse a health care provider or dispensing entity on a per unit basis for dispensing a six-month supply of contraceptives; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an insurer to limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply

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to short-term travel, accident-only, limited benefit or specified-disease health benefits plans.

I. The provisions of this section apply to individual or group health insurance policies, health care plans or certificates of insurance delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an insured is required to pay in accordance with the terms of an individual or group health

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insurance policy, health care plan or certificate of insurance; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health insurance coverage may elect to exclude prescription contraceptive drugs or items from the health insurance coverage purchased."

SECTION 6. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE EXCLUSION.--Coverage of vasectomy and male condoms pursuant to Section 5 of this 2019 act is excluded for high-deductible individual or group health insurance policies, health care plans or certificates of insurance with health savings accounts delivered or issued for delivery in this state until an insured's deductible has been met."

SECTION 7. Section 59A-46-44 NMSA 1978 (being Laws 2001, Chapter 14, Section 3, as amended) is amended to read:

"59A-46-44. COVERAGE FOR [~~PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES~~] CONTRACEPTION.--

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state that provides a prescription drug benefit shall provide,

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[~~coverage for prescription contraceptive drugs or devices approved by the food and drug administration~~] at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. [~~Coverage for food and drug administration-approved prescription contraceptive drugs or devices may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract~~] Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) enrollee cost sharing;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

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(4) any other restrictions or delays on the coverage.

C. A health maintenance organization may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an enrollee's health care provider determines that a particular drug or item is medically necessary, the individual or group health maintenance organization contract shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An individual or group health maintenance organization contract shall grant an enrollee an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an enrollee, the enrollee's representative or the enrollee's health care provider;

(2) defer to the determination of the

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enrollee's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. An individual or group health maintenance organization contract shall not require a prescription for any drug, item or service that is available without a prescription.

F. An individual or group health maintenance organization contract shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe six months of contraceptives at one time; or

(2) permit an individual or group health maintenance organization contract to limit coverage or impose cost sharing for an alternate method of contraception if an enrollee changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section apply to individual or group health maintenance organization contracts delivered or issued for delivery after January 1, 2020.

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I. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that an enrollee is required to pay in accordance with the terms of an individual or group health maintenance organization contract; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

[~~C.~~] J. A religious entity purchasing individual or group health maintenance organization coverage may elect to

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exclude prescription contraceptive drugs or devices from the health coverage purchased."

SECTION 8. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] COVERAGE EXCLUSION.--Coverage of vasectomy and male condoms pursuant to Section 7 of this 2019 act is excluded for high-deductible individual or group health maintenance organization contracts with health savings accounts delivered or issued for delivery in this state until an enrollee's deductible has been met."

SECTION 9. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COVERAGE FOR CONTRACEPTION.--

A. A health care plan delivered or issued for delivery in this state that provides a prescription drug benefit shall provide, at a minimum, the following coverage:

(1) at least one product or form of contraception in each of the contraceptive method categories identified by the federal food and drug administration;

(2) a sufficient number and assortment of oral contraceptive pills to reflect the variety of oral contraceptives approved by the federal food and drug administration; and

(3) clinical services related to the provision or use of contraception, including consultations, examinations,

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procedures, ultrasound, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

B. Except as provided in Subsection C of this section, the coverage required pursuant to this section shall not be subject to:

(1) cost sharing for subscribers;

(2) utilization review;

(3) prior authorization or step-therapy requirements; or

(4) any restrictions or delays on the coverage.

C. A health care plan may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method category of contraception without cost sharing by the subscriber; provided that when a subscriber's health care provider determines that a particular drug or item is medically necessary, the health care plan shall cover the brand-name pharmacy drug or item without cost sharing. A determination of medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

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D. A health care plan shall grant a subscriber an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on a subscriber, the subscriber's representative or the subscriber's health care provider;

(2) defer to the determination of the subscriber's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

E. A health care plan shall not require a prescription for any drug, item or service that is available without a prescription.

F. A health care plan shall provide coverage and shall reimburse a health care provider or dispensing entity on a per unit basis for dispensing a six-month supply of contraceptives; provided that the contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

(1) require a health care provider to

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prescribe six months of contraceptives at one time; or

(2) permit a health care plan to limit coverage or impose cost sharing for an alternate method of contraception if a subscriber changes contraceptive methods before exhausting a previously dispensed supply.

H. The provisions of this section shall not apply to short-term travel, accident-only, limited benefit or specified-disease health care plans.

I. The provisions of this section apply to health care plans delivered or issued for delivery after January 1, 2020.

J. For the purposes of this section:

(1) "contraceptive method categories identified by the federal food and drug administration":

(a) means tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

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(b) does not mean a product that has been recalled for safety reasons or withdrawn from the market;

(2) "cost sharing" means a deductible, copayment or coinsurance that a subscriber is required to pay in accordance with the terms of a health care plan; and

(3) "health care provider" means an individual licensed to provide health care in the ordinary course of business.

K. A religious entity purchasing individual or group health care plan coverage may elect to exclude prescription contraceptive drugs or items from the health insurance coverage purchased."

SECTION 10. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COVERAGE EXCLUSION.--Coverage of vasectomy and male condoms pursuant to Section 9 of this 2019 act is excluded for high-deductible health care plans with health savings accounts until a covered person's deductible has been met."

SECTION 11. CONTINGENT REPEAL.--Upon certification by the superintendent of insurance to the director of the legislative council service and the New Mexico compilation commission that federal law permits coverage of vasectomies and male condoms under high-deductible health benefits plans with health savings accounts, Sections 4, 6, 8 and 10 of this 2019 act are

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repealed.