

SENATE TAX, BUSINESS AND TRANSPORTATION
COMMITTEE SUBSTITUTE FOR
SENATE BILL 189

57TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2026

DISCUSSION DRAFT

AN ACT

RELATING TO INSURANCE; REQUIRING COVERAGE AND ELIMINATING COST-SHARING AND PRIOR AUTHORIZATION REQUIREMENTS FOR CERTAIN SEXUAL, REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES; CREATING THE REPRODUCTIVE HEALTH CARE ACCESS FUND; PROVIDING FOR A SURCHARGE ON CERTAIN ACCOUNTS CREATED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT; MAKING AN APPROPRIATION.

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] PREVENTIVE BENEFITS--NO COST SHARING.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage that is not subject

.233817.3

1 to cost-sharing provisions for:

2 (1) items or services that have in effect a
3 rating of "A" or "B" in the current recommendations of the
4 United States preventive services task force;

5 (2) immunizations that have in effect a
6 recommendation from the advisory committee on immunization
7 practices of the federal centers for disease control and
8 prevention, with respect to the insured for which immunization
9 is considered;

10 (3) with respect to infants, children and
11 adolescents, preventive care and screenings provided for in the
12 comprehensive guidelines supported by the health resources and
13 services administration of the United States department of
14 health and human services; and

15 (4) with respect to women, preventive care and
16 screenings as provided for in comprehensive guidelines
17 supported by the health resources and services administration
18 of the United States department of health and human services.

19 B. The provisions of this section shall not apply
20 to:

21 (1) a high-deductible health benefit plan
22 issued or renewed in this state until an eligible insured's
23 deductible has been met; or

24 (2) a short-term travel, an accident-only, a
25 hospital-indemnity-only, a limited-benefit or a specified-

1 disease health care plan.

2 C. As used in this section, "cost sharing" means a
3 deductible, copayment or coinsurance that an insured is
4 required to pay in accordance with the terms of group health
5 coverage."

6 SECTION 2. A new section of the Health Care Purchasing
7 Act is enacted to read:

8 "[NEW MATERIAL] ABORTION CARE--NO COST SHARING.--

9 A. Except as provided in Subsection C of this
10 section, all group health coverage, including self-insurance,
11 offered, issued, amended, delivered or renewed under the Health
12 Care Purchasing Act shall provide coverage for the total cost
13 of abortion care. The coverage shall not be subject to cost-
14 sharing provisions.

15 B. The provisions of this section shall not apply
16 to:

17 (1) a high-deductible health benefit plan
18 issued or renewed in this state until an eligible insured's
19 deductible has been met; or

20 (2) a short-term travel, an accident-only, a
21 hospital-indemnity-only, a limited-benefit or a disease-
22 specific group health plan.

23 C. As used in this section, "cost sharing" means a
24 deductible, copayment or coinsurance that an insured is
25 required to pay in accordance with the terms of group health

.233817.3

coverage."

SECTION 3. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PREGNANCY--SPECIAL ENROLLMENT PERIOD.--

A. Group health coverage, including self-insurance, offered, issued, amended, delivered or renewed under the Health Care Purchasing Act shall establish a special enrollment period to provide coverage to an uninsured person if the person is eligible to be insured and provides a certification from a health care provider to the insurer that the person is pregnant.

B. Coverage shall be effective before the end of the first month in which the uninsured person receives certification of the pregnancy, unless the person elects to have coverage effective on the first day of the month following the date that the person makes a plan selection."

SECTION 4. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING HEALTH CARE.--

A. All group health coverage, including self-insurance, offered, issued, amended, delivered or renewed under the Health Care Purchasing Act shall provide coverage for the total cost of gender-affirming health care. The coverage shall not be subject to cost-sharing provisions.

1 B. The provisions of this section shall not apply
2 to:

3 (1) a high-deductible health benefit plan
4 issued or renewed in this state until an eligible insured's
5 deductible has been met, unless allowed pursuant to federal
6 law; or

7 (2) a short-term travel, an accident-only, a
8 hospital-indemnity-only, a limited-benefit or a disease-
9 specific group health plan.

10 C. As used in this section:

11 (1) "cost sharing" means a deductible,
12 copayment or coinsurance that an insured is required to pay in
13 accordance with the terms of group health coverage; and

14 (2) "gender-affirming health care" means
15 psychological, behavioral, surgical, pharmaceutical and medical
16 care, services and supplies provided to support a person's
17 gender identity."

18 SECTION 5. Section 13-7-22 NMSA 1978 (being Laws 2019,
19 Chapter 263, Section 1) is amended to read:

20 "13-7-22. COVERAGE FOR CONTRACEPTION.--

21 A. Group health coverage, including any form of
22 self-insurance, offered, issued or renewed under the Health
23 Care Purchasing Act that provides coverage for prescription
24 drugs shall provide, at a minimum, the following coverage:

25 (1) at least one product or form of

.233817.3

1 contraception in each of the contraceptive method categories
2 identified by the federal food and drug administration;

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

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

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

15 (1) enrollee cost sharing;

16 (2) utilization review;

17 (3) prior authorization or step therapy
18 requirements; [~~or~~]

19 (4) quantity or fill limits if the practice
20 would result in an insured person receiving less than a
21 twelve-months' duration of contraception dispensed either at
22 one time or, if requested by the insured person at the point of
23 dispensing, over a twelve-month period; or

24 [~~(4)~~] (5) any other restrictions or delays on
25 the coverage.

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

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

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

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

24 (3) provide for a determination of the claim
25 according to a time frame and in a manner that takes into

.233817.3

1 account the nature of the claim and the medical exigencies
2 involved for a claim involving an urgent health care need.

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

6 F. A group health plan shall provide coverage and
7 shall reimburse a health care provider or dispensing entity on
8 a per-unit basis for dispensing [~~a six-month supply of~~
9 ~~contraceptives~~] contraception intended to last the insured for
10 a duration of twelve months, as permitted by the insured's
11 prescription, dispensed at one time; provided that the
12 contraceptives are prescribed and self-administered.

13 G. Nothing in this section shall be construed to:

14 (1) require a health care provider to
15 prescribe [~~six~~] twelve months of contraceptives at one time; or

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

20 H. The provisions of this section shall not apply
21 to:

22 (1) a high-deductible health benefit plan
23 issued or renewed in this state until an eligible insured's
24 deductible has been met; or

25 (2) a short-term travel, an accident-only, a

1 hospital-indemnity-only, a limited-benefit or a disease-
2 specific group health [~~plans~~] plan.

3 I. For the purposes of this section:

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

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

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

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

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

25 SECTION 6. Section 27-2-12.29 NMSA 1978 (being Laws 2019,

.233817.3

Chapter 263, Section 2) is amended to read:

"27-2-12.29. 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]~~ authority 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.

B. Nothing in this section shall be construed to:

(1) 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;

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

(3) permit the authority or a managed care organization to:

(a) impose restrictions or delays on coverage, including quantity or fill limits, if the practice would result in a recipient receiving less than a twelve-months' duration of contraception dispensed either at one time or, if requested by the recipient at the point of dispensing, over a twelve-month period;

(b) limit coverage or impose cost sharing for an alternative method of contraception if a recipient changes contraceptive methods before exhausting a previously dispensed supply of contraceptives;

(c) limit the quantity of contraceptive drugs or devices dispensed; or

(d) deny coverage for the continuous use of clinically appropriate contraception as determined by the prescribing provider.

C. As used in this section:

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

(2) "self-administered contraceptive" means 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; ulipristal acetate; levonorgestrel emergency contraception; and any other self-administered contraceptive method categories approved by the federal food and drug administration."

SECTION 7. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] FAMILY PLANNING AND RELATED SERVICES.--

1 A. When family planning services or family-
2 planning-related services are provided in accordance with the
3 Public Assistance Act, the authority shall authorize
4 reimbursement for services without quantity limitation,
5 utilization controls or prior authorization. The authority, an
6 intermediary or a managed care organization shall reimburse the
7 provider of those services.

8 B. A recipient shall be permitted to obtain family
9 planning services or family-planning-related services from a
10 health care provider licensed in New Mexico. The enrollment of
11 a recipient in a managed care organization shall not restrict a
12 recipient's choice of the licensed health care provider from
13 whom the recipient may receive those services or restrict the
14 obligation of the managed care organization to reimburse the
15 provider of those services.

16 C. When abortion care services are provided in
17 accordance with the Public Assistance Act, the authority, an
18 intermediary or a managed care organization shall reimburse the
19 provider of those services as distinct, non-bundled procedural
20 services and shall allow modifier codes, including increased
21 professional service, distinct procedural services and separate
22 structures, to reflect the increased time and training required
23 when applicable.

24 D. As used in this section:

25 (1) "family planning services" means services

1 covered by the federal Title X family planning program,
2 regardless of an individual's or a partner's age, sex or gender
3 identity; and

4 (2) "family-planning-related services" means
5 a medical diagnosis, treatment or preventive service that is
6 routinely provided pursuant to a family planning visit,
7 including:

- 8 (a) abortion care;
- 9 (b) miscarriage management;
- 10 (c) medically necessary evaluations or
11 preventive services, such as tobacco utilization screening,
12 counseling, testing and cessation services;
- 13 (d) cervical cancer screening and
14 prevention;
- 15 (e) prevention, diagnosis or treatment
16 of a sexually transmitted infection or sexually transmitted
17 disease; and
- 18 (f) mental health screening and
19 referral."

20 **SECTION 8.** A new section of the Public Assistance Act is
21 enacted to read:

22 "[NEW MATERIAL] EXCLUSIVE STATE FUNDING FOR CERTAIN
23 ENTITIES.--

24 A. The authority, a managed care organization or
25 any other intermediary responsible for reimbursing health care

.233817.3

1 providers under the state's medicaid program shall reimburse a
2 prohibited entity, as defined in Section 71113 of Public Law
3 119-21, for services provided using only state funds.

4 B. The requirements of this section do not apply to
5 services provided by a prohibited entity that is eligible for
6 reimbursement from the federal centers for medicare and
7 medicaid services at the time the services are provided.

8 C. As used in this section, "state's medicaid
9 program" means the state program acting to leverage federal
10 benefits for state residents pursuant to Title 19 or Title 20
11 of the federal Social Security Act."

12 SECTION 9. A new section of the Public Assistance Act is
13 enacted to read:

14 "[NEW MATERIAL] LACTATION SUPPORT.--

15 A. The authority shall ensure that medical
16 assistance coverage, including coverage provided by a managed
17 care organization, provides coverage for lactation support,
18 including:

19 (1) prior to delivery, single-user lactation
20 supplies and equipment; and

21 (2) comprehensive lactation support services
22 provided by a lactation care provider licensed pursuant to the
23 Lactation Care Provider Act.

24 B. Access to multi-user loaned breast pumps shall
25 be prioritized for persons with premature, medically fragile,

.233817.3

1 low birth weight infants or with lactation complications.
2 Access to multi-user loaned breast pumps shall be authorized by
3 a health care provider."

4 SECTION 10. A new section of the Public Assistance Act is
5 enacted to read:

6 "[NEW MATERIAL] GENDER-AFFIRMING HEALTH CARE.--

7 A. The authority shall ensure that medical
8 assistance coverage, including coverage provided by any managed
9 care organizations, provides coverage for gender-affirming
10 health care.

11 B. Coverage provided pursuant to this section:

12 (1) may be subject to other general exclusions
13 and limitations of medical assistance coverage, including
14 coordination of benefits, participating provider requirements
15 and restrictions on services provided by family or household
16 members; and

17 (2) shall not be subject to cost-sharing
18 provisions.

19 C. As used in this section:

20 (1) "cost sharing" means a deductible,
21 copayment or coinsurance that a recipient is required to pay in
22 accordance with the terms of a health care coverage plan; and

23 (2) "gender-affirming health care" means
24 psychological, behavioral, surgical, pharmaceutical and medical
25 care, services and supplies provided to support a person's

.233817.3

gender identity."

SECTION 11. A new section of Chapter 59A, Article 22
NMSA 1978 is enacted to read:

"[NEW MATERIAL] ABORTION CARE--NO COST SHARING.--

A. An individual or group health insurance policy,
health care plan or certificate of health insurance that is
delivered, issued for delivery or renewed in this state shall
provide coverage for the total cost of abortion care. The
coverage shall not be subject to cost-sharing provisions.

B. The provisions of this section shall not apply
to:

(1) a high-deductible health benefit plan
issued or renewed in this state until an eligible insured's
deductible has been met; or

(2) a short-term travel, an accident-only, a
hospital-indemnity-only, a limited-benefit or a specified-
disease health care plan.

C. As used in this section, "cost sharing" means a
deductible, copayment or coinsurance that an enrollee is
required to pay in accordance with the terms of an individual
or a group health insurance policy, health care plan or
certificate of insurance."

SECTION 12. 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

.233817.3

1 DRUGS OR DEVICES.--

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

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

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

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

19 (4) a sufficient quantity to allow for the
20 continuous use of clinically appropriate contraception as
21 determined by the prescribing provider; and

22 (5) United States food and drug
23 administration-approved, -cleared or -granted over-the-counter
24 contraception, including point-of-sale coverage for over-the-
25 counter contraception at in-network dispensing entities.

.233817.3

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

- 4 (1) cost sharing for insureds;
5 (2) utilization review;
6 (3) prior authorization or step-therapy
7 requirements; ~~[or]~~
8 (4) quantity or fill limits if the practice
9 would result in an insured receiving less than a twelve-months'
10 duration of contraception dispensed either at one time or, if
11 requested by the insured at the point of dispensing, over a
12 twelve-month period; or
13 ~~[(4)]~~ (5) any other restrictions or delays on
14 the coverage.

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

1 contraceptives and ability to adhere to the appropriate use of
2 the drug or item, as determined by the attending provider.

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

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

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

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

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

20 F. An insurer shall provide coverage and shall
21 reimburse a health care provider or dispensing entity on a per-
22 unit basis for dispensing ~~[a six-month supply of~~
23 ~~contraceptives]~~ contraception intended to last the insured for
24 a duration of twelve months, as permitted by the covered
25 person's prescription, dispensed at one time; provided that the

.233817.3

contraceptives are prescribed and self-administered.

G. Nothing in this section shall be construed to:

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

(2) permit an insurer to:

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

(b) limit the quantity of contraceptives dispensed based on the number of months left in the plan year; or

(3) permit an insurer or a pharmacy benefits manager to deny coverage for the continuous use of clinically appropriate contraception as determined by the prescribing provider.

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

~~[H.]~~ I. The provisions of this section shall not apply to:

(1) a high-deductible health benefit plan issued or renewed in this state until an eligible insured's

1 deductible has been met; or

2 (2) a short-term travel, an accident-only, a
3 hospital-indemnity-only, a limited-benefit or a specified-
4 disease [~~policies~~] policy.

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

9 J. For the purposes of this section:

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

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

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

25 (2) "cost sharing" means a deductible,

.233817.3

1 copayment or coinsurance that an insured is required to pay in
2 accordance with the terms of an individual or group health
3 insurance policy, health care plan or certificate of insurance;
4 and

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

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

12 SECTION 13. A new section of Chapter 59A, Article 22
13 NMSA 1978 is enacted to read:

14 "[NEW MATERIAL] SPECIAL ENROLLMENT PERIOD--PREGNANCY.--

15 A. An individual or group health insurance policy,
16 health care plan or certificate of health insurance that is
17 delivered, issued for delivery or renewed in this state shall
18 establish a special enrollment period to provide coverage to an
19 uninsured person if the person is eligible to be insured and
20 provides a certification from a health care provider to the
21 insurer that the person is pregnant.

22 B. Coverage shall be effective before the end of
23 the first month in which the person receives certification of
24 the pregnancy, unless the person elects to have coverage
25 effective on the first day of the month following the date that

1 the person makes a plan selection."

2 SECTION 14. A new section of Chapter 59A, Article 22
3 NMSA 1978 is enacted to read:

4 "[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING HEALTH
5 CARE.--

6 A. An individual or group health insurance policy,
7 health care plan or certificate of health insurance that is
8 delivered, issued for delivery or renewed in this state shall
9 provide coverage for the total cost of gender-affirming health
10 care. The coverage shall not be subject to cost-sharing
11 provisions.

12 B. The provisions of this section shall not apply
13 to:

14 (1) a high-deductible health benefit plan
15 issued or renewed in this state until an eligible insured's
16 deductible has been met; or

17 (2) a short-term travel, an accident-only, a
18 hospital-indemnity-only, a limited-benefit or a specified-
19 disease health care plan.

20 C. As used in this section:

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

.233817.3

1 (2) "gender-affirming health care" means
2 psychological, behavioral, surgical, pharmaceutical and medical
3 care, services and supplies provided to support a person's
4 gender identity."

5 **SECTION 15.** A new section of Chapter 59A, Article 23
6 NMSA 1978 is enacted to read:

7 "NEW MATERIAL ABORTION CARE--NO COST SHARING.--

8 A. A group or blanket health insurance policy,
9 health care plan or certificate of health insurance that is
10 delivered, issued for delivery or renewed in this state shall
11 provide coverage for the total cost of abortion care. The
12 coverage shall not be subject to cost-sharing provisions.

13 B. The provisions of this section shall not apply
14 to:

15 (1) a high-deductible health benefit plan
16 issued or renewed in this state until an eligible insured's
17 deductible has been met; or

18 (2) a short-term travel, an accident-only, a
19 hospital-indemnity-only, a limited-benefit or a specified-
20 disease health care plan.

21 C. As used in this section, "cost sharing" means a
22 deductible, copayment or coinsurance that an insured is
23 required to pay in accordance with the terms of an individual
24 or a group health insurance policy, health care plan or
25 certificate of insurance."

1 **SECTION 16.** Section 59A-23-7.14 NMSA 1978 (being Laws
2 2019, Chapter 263, Section 5) is amended to read:

3 "59A-23-7.14. COVERAGE FOR CONTRACEPTION.--

4 A. ~~[Each individual and group]~~ A group or blanket
5 health insurance policy, health care plan ~~[and]~~ or certificate
6 of health insurance that is delivered, ~~[or]~~ issued for delivery
7 or renewed in this state that provides a prescription drug
8 benefit shall provide, at a minimum, the following coverage:

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

12 (2) a sufficient number and assortment of oral
13 contraceptive pills to reflect the variety of oral
14 contraceptives approved by the federal food and drug
15 administration; ~~[and]~~

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

21 (4) a sufficient quantity to allow for the
22 continuous use of clinically appropriate contraception as
23 determined by the prescribing provider; and

24 (5) United States food and drug
25 administration-approved, -cleared or -granted over-the-counter

.233817.3

1 contraception, including point-of-sale coverage for over-the-
2 counter contraception at in-network dispensing entities.

3 B. ~~[Except as provided in Subsection C of this~~
4 ~~section]~~ The coverage required pursuant to this section shall
5 not be subject to:

- 6 (1) cost sharing for insureds;
7 (2) utilization review;
8 (3) prior authorization or step-therapy
9 requirements; ~~[or]~~
10 (4) quantity or fill limits if the practice
11 would result in a covered person receiving less than a
12 twelve-months' duration of contraception dispensed either at
13 one time or, if requested by the insured at the point of
14 dispensing, over a twelve-month period; or

15 ~~[(4)]~~ (5) any restrictions or delays on the
16 coverage.

17 C. An insurer may discourage brand-name pharmacy
18 drugs or items by applying cost sharing to brand-name drugs or
19 items when at least one generic or therapeutic equivalent is
20 covered within the same method category of contraception
21 without cost sharing by the insured; provided that when an
22 insured's health care provider determines that a particular
23 drug or item is medically necessary, the individual or group
24 health insurance policy, health care plan or certificate of
25 health insurance shall cover the brand-name pharmacy drug or

1 item without cost sharing. A determination of medical
2 necessity may include considerations such as severity of side
3 effects, differences in permanence or reversibility of
4 contraceptives and ability to adhere to the appropriate use of
5 the drug or item, as determined by the attending provider.

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

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

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

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

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

23 F. An individual or group health insurance policy,
24 health care plan or certificate of health insurance shall
25 provide coverage and shall reimburse a health care provider or

.233817.3

1 dispensing entity on a per unit basis for dispensing [~~a six-~~
2 ~~month supply of contraceptives~~] contraception intended to last
3 the insured for a duration of twelve months, as permitted by
4 the insured's prescription, dispensed at one time; provided
5 that the contraceptives are prescribed and self-administered.

6 G. Nothing in this section shall be construed to:

7 (1) require a health care provider to
8 prescribe [~~six~~] twelve months of contraceptives at one time; or

9 (2) permit an insurer to:

10 (a) limit coverage or impose cost
11 sharing for an alternate method of contraception if an insured
12 changes contraceptive methods before exhausting a previously
13 dispensed supply;

14 (b) limit the quantity of contraceptives
15 dispensed based on the number of months left in the plan year;
16 or

17 (c) deny coverage for the continuous use
18 of clinically appropriate contraception as determined by the
19 prescribing provider.

20 H. A religious entity purchasing individual or
21 group health insurance coverage may elect to exclude
22 prescription contraceptive drugs or items from the health
23 insurance coverage purchased.

24 [~~H.~~] I. The provisions of this section shall not
25 apply to:

1 (1) a high-deductible health benefit plan
 2 issued or renewed in this state until an eligible insured's
 3 deductible has been met; or

4 (2) a short-term travel, an accident-only, a
 5 hospital-indemnity-only, a limited-benefit or a specified-
 6 disease health benefits [plans] plan.

7 ~~[I. The provisions of this section apply to~~
 8 ~~individual or group health insurance policies, health care~~
 9 ~~plans or certificates of insurance delivered or issued for~~
 10 ~~delivery after January 1, 2020.]~~

11 J. For the purposes of this section:

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

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

25 (b) does not mean a product that has

.233817.3

1 been recalled for safety reasons or withdrawn from the market;

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

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

10 ~~[K. A religious entity purchasing individual or~~
11 ~~group health insurance coverage may elect to exclude~~
12 ~~prescription contraceptive drugs or items from the health~~
13 ~~insurance coverage purchased.]"~~

14 SECTION 17. A new section of Chapter 59A, Article 23
15 NMSA 1978 is enacted to read:

16 "[NEW MATERIAL] SPECIAL ENROLLMENT PERIOD--PREGNANCY.--

17 A. A group or blanket health insurance policy,
18 health care plan or certificate of health insurance that is
19 delivered, issued for delivery or renewed in this state shall
20 establish a special enrollment period to provide coverage to an
21 uninsured person if the person is eligible to be insured and
22 provides a certification from a health care provider to the
23 insurer that the person is pregnant.

24 B. Coverage shall be effective before the end of
25 the first month in which the uninsured person receives

.233817.3

1 certification of the pregnancy, unless the person elects to
2 have coverage effective on the first day of the month following
3 the date that the person makes a plan selection."

4 SECTION 18. A new section of Chapter 59A, Article 23
5 NMSA 1978 is enacted to read:

6 "[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING HEALTH
7 CARE.--

8 A. A group or blanket health insurance policy,
9 health care plan or certificate of health insurance that is
10 delivered, issued for delivery or renewed in this state shall
11 provide coverage for the total cost of gender-affirming health
12 care. The coverage shall not be subject to cost-sharing
13 provisions.

14 B. The provisions of this section shall not apply
15 to:

16 (1) a high-deductible health benefit plan
17 issued or renewed in this state until an eligible insured's
18 deductible has been met; or

19 (2) a short-term travel, an accident-only, a
20 hospital-indemnity-only, a limited-benefit or a specified-
21 disease health care plan.

22 C. As used in this section:

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

.233817.3

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

3 (2) "gender-affirming health care" means
4 psychological, behavioral, surgical, pharmaceutical and medical
5 care, services and supplies provided to support a person's
6 gender identity."

7 SECTION 19. A new section of the New Mexico Health
8 Insurance Exchange Act is enacted to read:

9 "[NEW MATERIAL] REPRODUCTIVE HEALTH CARE ACCESS
10 FUND.--The "reproductive health care access fund" is created as
11 a nonreverting fund in the state treasury. The fund consists
12 of distributions, appropriations, gifts, grants, donations,
13 income from investment of the fund and any other revenue
14 credited to the fund. The health care authority shall
15 administer the fund, and money in the fund is subject to
16 appropriation by the legislature for the purpose of funding
17 programs and initiatives that provide access to affordable
18 reproductive health care. Expenditures shall be by warrant of
19 the secretary of finance and administration pursuant to
20 vouchers signed by the secretary of health care authority or
21 the secretary's authorized representative."

22 SECTION 20. A new section of the New Mexico Health
23 Insurance Exchange Act is enacted to read:

24 "[NEW MATERIAL] ABORTION SERVICES SEGREGATED ACCOUNT--
25 REPORTING--SURCHARGE.--

1 A. A health insurance issuer offering a health
2 benefit plan that covers abortion services through the exchange
3 shall:

4 (1) no later than July 1, 2026, submit a
5 report to the superintendent that details the amount of money
6 present in a segregated account created pursuant to 42 U.S.C.
7 Section 18023; and

8 (2) by March 31, 2027 and each March 31
9 thereafter, report to the superintendent the receipts,
10 disbursements, interest accrued and ending balance for a
11 segregated account created pursuant to 42 U.S.C. Section 18023.
12 The report shall document all money added to segregated
13 accounts during the previous calendar year and shall include
14 any related documentation required by the superintendent.

15 B. Upon receipt of a report required pursuant to
16 Subsection A of this section, the superintendent shall assess a
17 surcharge on each segregated account created pursuant to 42
18 U.S.C. Section 18023 in an amount equal to the segregated
19 account's balance to be paid on or before the twenty-fifth day
20 of the month following the month in which the surcharge is
21 assessed. All money collected pursuant to the surcharge shall
22 be deposited into the reproductive health care access fund."

23 **SECTION 21.** A new section of the Health Maintenance
24 Organization Law is enacted to read:

25 "[NEW MATERIAL] ABORTION CARE--NO COST SHARING.--

.233817.3

1 A. An individual or group health maintenance
2 organization contract that is delivered, issued for delivery or
3 renewed in this state shall provide coverage for the total cost
4 of abortion care. The coverage shall not be subject to cost-
5 sharing provisions.

6 B. The provisions of this section shall not apply
7 to:

8 (1) a high-deductible health benefit plan
9 issued or renewed in this state until an eligible enrollee's
10 deductible has been met; or

11 (2) a short-term travel, an accident-only, a
12 hospital-indemnity-only, a limited-benefit or a specified-
13 disease health care plan.

14 C. As used in this section, "cost sharing" means a
15 deductible, copayment or coinsurance that an enrollee is
16 required to pay in accordance with the terms of a contract."

17 **SECTION 22.** Section 59A-46-44 NMSA 1978 (being Laws
18 2001, Chapter 14, Section 3, as amended) is amended to read:

19 "59A-46-44. COVERAGE FOR CONTRACEPTION.--

20 A. ~~Each~~ An individual ~~and~~ or group health
21 maintenance organization contract delivered or issued for
22 delivery in this state that provides a prescription drug
23 benefit shall provide, at a minimum, the following coverage:

24 (1) at least one product or form of
25 contraception in each of the contraceptive method categories

1 identified by the federal food and drug administration;

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

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

11 (4) a sufficient quantity to allow for the
12 continuous use of clinically appropriate contraception as
13 determined by the prescribing provider; and

14 (5) United States food and drug
15 administration-approved, -cleared or -granted over-the-counter
16 contraception, including point-of-sale coverage for over-the-
17 counter contraception at in-network dispensing entities.

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

21 (1) enrollee cost sharing;
22 (2) utilization review;
23 (3) prior authorization or step-therapy
24 requirements; ~~or~~

25 (4) quantity or fill limits if the practice

.233817.3

1 would result in an enrollee receiving less than a twelve-
2 months' duration of contraception dispensed either at one time
3 or, if requested by the enrollee at the point of dispensing,
4 over a twelve-month period; or

5 [~~4~~] (5) any other restrictions or delays on
6 the coverage.

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

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

25 (1) be easily accessible, transparent,

1 sufficiently expedient and not unduly burdensome on an
2 enrollee, the enrollee's representative or the enrollee's
3 health care provider;

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

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

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

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

19 G. Nothing in this section shall be construed to:

20 (1) require a health care provider to
21 prescribe [~~six~~] twelve months of contraceptives at one time; or

22 (2) permit an individual or group health
23 maintenance organization contract to limit coverage or impose
24 cost sharing for an alternate method of contraception if an
25 enrollee changes contraceptive methods before exhausting a

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1 previously dispensed supply.

2 H. A religious entity purchasing individual or
3 group health maintenance organization coverage may elect to
4 exclude prescription contraceptive drugs or devices from the
5 health coverage purchased.

6 ~~[H.]~~ I. The provisions of this section shall not
7 apply to:

8 (1) a high-deductible health benefit plan
9 issued or renewed in this state until an enrollee's deductible
10 has been met; or

11 (2) a short-term travel, an accident-only, a
12 hospital-indemnity-only, a limited-benefit or a specified
13 disease health benefits [plans] plan.

14 ~~[I. The provisions of this section apply to~~
15 ~~individual or group health maintenance organization contracts~~
16 ~~delivered or issued for delivery after January 1, 2020.]~~

17 J. For the purposes of this section:

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

20 (a) means tubal ligation; sterilization
21 implant; copper intrauterine device; intrauterine device with
22 progestin; implantable rod; contraceptive shot or injection;
23 combined oral contraceptives; extended or continuous use oral
24 contraceptives; progestin-only oral contraceptives; patch;
25 vaginal ring; diaphragm with spermicide; sponge with

1 spermicide; cervical cap with spermicide; male and female
 2 condoms; spermicide alone; vasectomy; ulipristal acetate;
 3 levonorgestrel emergency contraception; and any additional
 4 contraceptive method categories approved by the federal food
 5 and drug administration; and

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

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

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

15 ~~[K. A religious entity purchasing individual or~~
 16 ~~group health maintenance organization coverage may elect to~~
 17 ~~exclude prescription contraceptive drugs or devices from the~~
 18 ~~health coverage purchased.]"~~

19 **SECTION 23.** A new section of the Health Maintenance
 20 Organization Law is enacted to read:

21 "[NEW MATERIAL] SPECIAL ENROLLMENT PERIOD--PREGNANCY.--

22 A. An individual or group health maintenance
 23 organization contract delivered or issued for delivery in this
 24 state shall establish a special enrollment period to provide
 25 coverage to an uninsured person if the person is eligible to be

.233817.3

1 insured and provides a certification from a health care
2 provider to the insurer that the person is pregnant.

3 B. Coverage shall be effective before the end of
4 the first month in which the person receives certification of
5 the pregnancy, unless the person elects to have coverage
6 effective on the first day of the month following the date that
7 the person makes a plan selection."

8 SECTION 24. A new section of the Health Maintenance
9 Organization Law is enacted to read:

10 "[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING HEALTH
11 CARE.--

12 A. An individual or group health maintenance
13 organization contract delivered or issued for delivery in this
14 state shall provide coverage for the total cost of gender-
15 affirming health care. The coverage shall not be subject to
16 cost-sharing provisions.

17 B. The provisions of this section shall not apply
18 to:

19 (1) a high-deductible health benefit plan
20 issued or renewed in this state until an eligible enrollee's
21 deductible has been met; or

22 (2) a short-term travel, an accident-only, a
23 hospital-indemnity-only, a limited-benefit or a specified-
24 disease health care plan.

25 C. As used in this section:

.233817.3

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

5 (2) "gender-affirming health care" means
6 psychological, behavioral, surgical, pharmaceutical and medical
7 care, services and supplies provided to support a person's
8 gender identity."

9 SECTION 25. A new section of the Nonprofit Health Care
10 Plan Law is enacted to read:

11 "[NEW MATERIAL] ABORTION CARE--NO COST SHARING.--

12 A. A health care plan delivered or issued for
13 delivery in this state shall provide coverage for the total
14 cost of abortion care that shall not be subject to cost-
15 sharing provisions.

16 B. The provisions of this section shall not apply
17 to:

18 (1) a high-deductible health benefit plan
19 issued or renewed in this state until an eligible subscriber's
20 deductible has been met; or

21 (2) a short-term travel, an accident-only, a
22 hospital-indemnity-only, a limited-benefit or a specified-
23 disease health care plan.

24 C. As used in this section, "cost sharing" means a
25 deductible, copayment or coinsurance that a subscriber is

.233817.3

1 required to pay in accordance with the terms of a health care
2 plan."

3 SECTION 26. Section 59A-47-45.5 NMSA 1978 (being Laws
4 2019, Chapter 263, Section 9) is amended to read:

5 "59A-47-45.5. COVERAGE FOR CONTRACEPTION.--

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

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

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

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

21 (4) a sufficient quantity to allow for the
22 continuous use of clinically appropriate contraception as
23 determined by the prescribing provider; and

24 (5) United States food and drug
25 administration-approved, -cleared or -granted over-the-counter

.233817.3

contraception, including point-of-sale coverage for over-the-counter contraception at in-network dispensing entities.

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) quantity or fill limits if the practice would result in a subscriber receiving less than a twelve-months' duration of contraception dispensed either at one time or, if requested by the subscriber at the point of dispensing, over a twelve-month period; or

~~[(4)]~~ (5) 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

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1 considerations such as severity of side effects, differences in
2 permanence or reversibility of contraceptives and ability to
3 adhere to the appropriate use of the drug or item, as
4 determined by the attending provider.

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

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

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

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

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

23 F. A health care plan shall provide coverage and
24 shall reimburse a health care provider or dispensing entity on
25 a per unit basis for dispensing ~~[a six-month supply of~~

~~contraceptives]~~ contraception intended to last the subscriber
for a duration of twelve months, as permitted by the
subscriber's prescription, dispensed 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]~~ twelve 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; or

(3) permit a plan or pharmacy benefits manager
to:

(a) limit the quantity of contraceptives
dispensed based on the number of months left in the plan year;
or

(b) deny coverage for the continuous use
of clinically appropriate contraception as determined by the
prescribing provider.

H. A religious entity purchasing individual or
group health care plan may elect to exclude prescription
contraceptive drugs or devices from the health coverage
purchased.

~~[H.]~~ I. The provisions of this section shall not

1 apply to:

2 (1) a high-deductible health benefit plan
3 issued or renewed in this state until a subscriber's deductible
4 has been met; or

5 (2) a short-term travel, an accident-only, a
6 hospital-indemnity-only, a limited-benefit or a specified-
7 disease health care [plans] plan.

8 ~~[I. The provisions of this section apply to health~~
9 ~~care plans delivered or issued for delivery after January 1,~~
10 ~~2020.]~~

11 J. For the purposes of this section:

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

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

25 (b) does not mean a product that has

1 been recalled for safety reasons or withdrawn from the market;

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

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

8 ~~[K. A religious entity purchasing individual or~~
9 ~~group health care plan coverage may elect to exclude~~
10 ~~prescription contraceptive drugs or items from the health~~
11 ~~insurance coverage purchased.]"~~

12 SECTION 27. A new section of the Nonprofit Health Care
13 Plan Law is enacted to read:

14 "[NEW MATERIAL] SPECIAL ENROLLMENT PERIOD--PREGNANCY.--

15 A. A health care plan delivered or issued for
16 delivery in this state shall establish a special enrollment
17 period to provide coverage to an uninsured person if the person
18 is eligible to be insured and provides a certification from a
19 health care provider to the insurer that the person is
20 pregnant.

21 B. Coverage shall be effective before the end of
22 the first month in which the uninsured person receives
23 certification of the pregnancy, unless the person elects to
24 have coverage effective on the first day of the month following
25 the date that the person makes a plan selection."

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1 **SECTION 28.** A new section of the Nonprofit Health Care
2 Plan Law is enacted to read:

3 "[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING HEALTH
4 CARE.--

5 A. A health care plan delivered or issued for
6 delivery in this state shall provide coverage for the total
7 cost of gender-affirming health care. The coverage shall not
8 be subject to cost-sharing provisions.

9 B. The provisions of this section shall not apply
10 to:

11 (1) a high-deductible health benefit plan
12 issued or renewed in this state until an eligible subscriber's
13 deductible has been met; or

14 (2) a short-term travel, an accident-only, a
15 hospital-indemnity-only, a limited-benefit or a specified-
16 disease health care plan.

17 C. As used in this section:

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

21 (2) "gender-affirming health care" means
22 psychological, behavioral, surgical, pharmaceutical and medical
23 care, services and supplies provided to support a person's
24 gender identity."

25 **SECTION 29. APPLICABILITY.**--The provisions of Sections 1

1 through 7, 9 through 18 and 21 through 28 of this act apply to
2 policies, plans, contracts and certificates delivered or issued
3 for delivery or renewed, extended or amended in this state
4 beginning January 1, 2027.

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underscored material = new
[~~bracketed material~~] = delete