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SENATE BILL 189

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

INTRODUCED BY

Heather Berghmans

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.

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 to cost-sharing provisions for:

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

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

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

11 (4) with respect to women, preventive care and  
12 screenings as provided for in comprehensive guidelines  
13 supported by the health resources and services administration  
14 of the United States department of health and human services.

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 specified-  
22 disease health care 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

1 coverage."

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

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

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

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

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

16 (2) a short-term travel, an accident-only, a  
17 hospital-indemnity-only, a limited-benefit or a disease-  
18 specific group health plan.

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

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

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

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

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

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

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

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

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

23                   (1) a high-deductible health benefit plan  
24 issued or renewed in this state until an eligible insured's  
25 deductible has been met, unless allowed pursuant to federal

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1 law; or

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

5 C. As used in this section:

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

9 (2) "gender-affirming care" means a procedure,  
10 service, drug, device or product that a physical or behavioral  
11 health care provider prescribes to treat an individual for  
12 incongruence between the individual's gender identity and the  
13 individual's sex assignment at birth."

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

16 "13-7-22. COVERAGE FOR CONTRACEPTION.--

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

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

24 (2) a sufficient number and assortment of oral  
25 contraceptive pills to reflect the variety of oral

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1 contraceptives approved by the federal food and drug  
2 administration; and

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

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

- 11 (1) enrollee cost sharing;  
12 (2) utilization review;  
13 (3) prior authorization or step therapy  
14 requirements; [~~or~~]  
15 (4) quantity or fill limits if the practice  
16 would result in an insured person receiving less than a  
17 twelve-months' duration of contraception dispensed either at  
18 one time or, if requested by the insured person at the point of  
19 dispensing, over a twelve-month period; or  
20 [~~(4)~~] (5) any other restrictions or delays on  
21 the coverage.

22 C. A group health plan may discourage brand-name  
23 pharmacy drugs or items by applying cost sharing to brand-name  
24 drugs or items when at least one generic or therapeutic  
25 equivalent is covered within the same method of contraception

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1 without patient cost sharing; provided that when an enrollee's  
2 health care provider determines that a particular drug or item  
3 is medically necessary, the group health plan shall cover the  
4 brand-name pharmacy drug or item without cost sharing. Medical  
5 necessity may include considerations such as severity of side  
6 effects, differences in permanence or reversibility of  
7 contraceptives and ability to adhere to the appropriate use of  
8 the drug or item, as determined by the attending provider.

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

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

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

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

24 E. A group health plan shall not require a  
25 prescription for any drug, item or service that is available

1 without a prescription.

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

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

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

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

16 H. 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 insured'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 disease-  
23 specific group health [plans] plan.

24 I. For the purposes of this section:

25 (1) "contraceptive method categories



1 identified by the federal food and drug administration":

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

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

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

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

21 SECTION 6. Section 27-2-12.29 NMSA 1978 (being Laws 2019,  
22 Chapter 263, Section 2) is amended to read:

23 "27-2-12.29. MEDICAL ASSISTANCE--REIMBURSEMENT FOR A ONE-  
24 YEAR SUPPLY OF COVERED PRESCRIPTION CONTRACEPTIVE DRUGS OR  
25 DEVICES.--

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

7           B. Nothing in this section shall be construed to:

8               (1) limit a recipient's freedom to choose or  
9 change the method of family planning to be used, regardless of  
10 whether the recipient has exhausted a previously dispensed  
11 supply of contraceptives;

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

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

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

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

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

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

6 C. As used in this section:

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

10 (2) "self-administered contraceptive" means  
11 combined oral contraceptives; extended or continuous use oral  
12 contraceptives; progestin-only oral contraceptives; patch;  
13 vaginal ring; diaphragm with spermicide; sponge with  
14 spermicide; cervical cap with spermicide; male and female  
15 condoms; spermicide alone; ulipristal acetate; levonorgestrel  
16 emergency contraception; and any other self-administered  
17 contraceptive method categories approved by the federal food  
18 and drug administration."

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

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

22 A. When family planning services or family-  
23 planning-related services are provided in accordance with the  
24 Public Assistance Act, the authority shall authorize  
25 reimbursement for services without quantity limitation,

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1 utilization controls or prior authorization. The authority, an  
2 intermediary or a managed care organization shall reimburse the  
3 provider of those services.

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

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

20 D. As used in this section:

21 (1) "family planning services" means services  
22 covered by the federal Title X family planning program,  
23 regardless of an individual's or a partner's age, sex or gender  
24 identity; and

25 (2) "family-planning-related services" means

1 a medical diagnosis, treatment or preventive service that is  
2 routinely provided pursuant to a family planning visit,  
3 including:

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

16 SECTION 8. A new section of the Public Assistance Act is  
17 enacted to read:

18 "[NEW MATERIAL] LACTATION SUPPORT.--

19 A. The authority shall ensure that medical  
20 assistance coverage, including coverage provided by a managed  
21 care organization, provides coverage for lactation support,  
22 including:

- 23 (1) prior to delivery, single-user lactation  
24 supplies and equipment; and
- 25 (2) comprehensive lactation support services

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1 provided by a lactation care provider licensed pursuant to the  
2 Lactation Care Provider Act.

3 B. Access to multi-user loaned breast pumps shall  
4 be prioritized for persons with premature, medically fragile,  
5 low birth weight infants or with lactation complications.  
6 Access to multi-user loaned breast pumps shall be authorized by  
7 a health care provider."

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

10 "[NEW MATERIAL] GENDER-AFFIRMING CARE.--

11 A. The authority shall ensure that medical  
12 assistance coverage, including coverage provided by any managed  
13 care organizations, provides coverage for gender-affirming  
14 care.

15 B. Coverage provided pursuant to this section:

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

21 (2) shall not be subject to cost-sharing  
22 provisions.

23 C. As used in this section:

24 (1) "cost sharing" means a deductible,  
25 copayment or coinsurance that a recipient is required to pay in

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1 accordance with the terms of a health care coverage plan; and

2 (2) "gender-affirming care" means a procedure,  
3 service, drug, device or product that a physical or behavioral  
4 health care provider prescribes to treat an individual for  
5 incongruence between the individual's gender identity and the  
6 individual's sex assignment at birth."

7 SECTION 10. A new section of Chapter 59A, Article 22  
8 NMSA 1978 is enacted to read:

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

10 A. An individual or group health insurance policy,  
11 health care plan or certificate of health insurance that is  
12 delivered, issued for delivery or renewed in this state shall  
13 provide coverage for the total cost of abortion care. The  
14 coverage shall not be subject to cost-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 specified-  
22 disease health care plan.

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

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1 or a group health insurance policy, health care plan or  
2 certificate of insurance."

3 SECTION 11. Section 59A-22-42 NMSA 1978 (being Laws  
4 2001, Chapter 14, Section 1, as amended) is amended to read:

5 "59A-22-42. COVERAGE FOR PRESCRIPTION CONTRACEPTIVE  
6 DRUGS OR DEVICES.--

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

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

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

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

24 (4) a sufficient quantity to allow for the  
25 continuous use of clinically appropriate contraception as



1 determined by the prescribing provider; and

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

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

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

18 ~~[(4)]~~ (5) any other restrictions or delays on  
19 the coverage.

20 C. An insurer may discourage brand-name pharmacy  
21 drugs or items by applying cost sharing to brand-name drugs or  
22 items when at least one generic or therapeutic equivalent is  
23 covered within the same method of contraception without patient  
24 cost sharing; provided that when an insured's health care  
25 provider determines that a particular drug or item is medically

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1 necessary, the individual or group health insurance policy,  
2 health care plan or certificate of insurance shall cover the  
3 brand-name pharmacy drug or item without cost sharing. Medical  
4 necessity may include considerations such as severity of side  
5 effects, differences in permanence or reversibility of  
6 contraceptives and ability to adhere to the appropriate use of  
7 the drug or item, as determined by the attending provider.

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

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

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

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

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

25 F. An insurer shall provide coverage and shall

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

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

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

11 (2) permit an insurer to:

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

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

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

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

1 coverage purchased.

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

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

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

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

14           J. For the purposes of this section:

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

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

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1 contraceptive method categories approved by the federal food  
2 and drug administration; and

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

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

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

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

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

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

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

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1 insurer that the person is pregnant.

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

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

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

10 A. An individual or group health insurance policy,  
11 health care plan or certificate of health insurance that is  
12 delivered, issued for delivery or renewed in this state shall  
13 provide coverage for the total cost of gender-affirming care.  
14 The coverage shall not be subject to cost-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 specified-  
22 disease health care plan.

23 C. As used in this section:

24 (1) "cost sharing" means a deductible,  
25 copayment or coinsurance that an insured is required to pay in

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1 accordance with the terms of an individual or group health  
2 insurance policy, health care plan or certificate of insurance;  
3 and

4 (2) "gender-affirming care" means a procedure,  
5 service, drug, device or product that a physical or behavioral  
6 health care provider prescribes to treat an individual for  
7 incongruence between the individual's gender identity and the  
8 individual's sex assignment at birth."

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

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

12 A. A group or blanket health insurance policy,  
13 health care plan or certificate of health insurance that is  
14 delivered, issued for delivery or renewed in this state shall  
15 provide coverage for the total cost of abortion care. The  
16 coverage shall not be subject to 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 insured'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, "cost sharing" means a

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

5 SECTION 15. Section 59A-23-7.14 NMSA 1978 (being Laws  
6 2019, Chapter 263, Section 5) is amended to read:

7 "59A-23-7.14. COVERAGE FOR CONTRACEPTION.--

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

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

16 (2) a sufficient number and assortment of oral  
17 contraceptive pills to reflect the variety of oral  
18 contraceptives approved by the federal food and drug  
19 administration; ~~[and]~~

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

25 (4) a sufficient quantity to allow for the



1 continuous use of clinically appropriate contraception as  
2 determined by the prescribing provider; and  
3 (5) United States food and drug  
4 administration-approved, -cleared or -granted over-the-counter  
5 contraception, including point-of-sale coverage for over-the-  
6 counter contraception at in-network dispensing entities.

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

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

19 ~~[4]~~ (5) any restrictions or delays on the  
20 coverage.

21 C. An insurer may discourage brand-name pharmacy  
22 drugs or items by applying cost sharing to brand-name drugs or  
23 items when at least one generic or therapeutic equivalent is  
24 covered within the same method category of contraception  
25 without cost sharing by the insured; provided that when an

1 insured's health care provider determines that a particular  
2 drug or item is medically necessary, the individual or group  
3 health insurance policy, health care plan or certificate of  
4 health insurance shall cover the brand-name pharmacy drug or  
5 item without cost sharing. A determination of medical  
6 necessity may include considerations such as severity of side  
7 effects, differences in permanence or reversibility of  
8 contraceptives and ability to adhere to the appropriate use of  
9 the drug or item, as determined by the attending provider.

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

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

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

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

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

1 prescription.

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

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

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

13 (2) permit an insurer to:

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

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

21 (c) deny coverage for the continuous use  
22 of clinically appropriate contraception as determined by the  
23 prescribing provider.

24 H. A religious entity purchasing individual or  
25 group health insurance coverage may elect to exclude

1 prescription contraceptive drugs or items from the health  
2 insurance coverage purchased.

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

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

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

11 ~~[I. The provisions of this section apply to~~  
12 ~~individual or group health insurance policies, health care~~  
13 ~~plans or certificates of insurance delivered or issued for~~  
14 ~~delivery after January 1, 2020.]~~

15 J. For the purposes of this section:

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

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

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

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

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

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

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

18 SECTION 16. A new section of Chapter 59A, Article 23  
19 NMSA 1978 is enacted to read:

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

21 A. A group or blanket health insurance policy,  
22 health care plan or certificate of health insurance that is  
23 delivered, issued for delivery or renewed in this state shall  
24 establish a special enrollment period to provide coverage to an  
25 uninsured person if the person is eligible to be insured and

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

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

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

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

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

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

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

5 (2) "gender-affirming care" means a procedure,  
6 service, drug, device or product that a physical or behavioral  
7 health care provider prescribes to treat an individual for  
8 incongruence between the individual's gender identity and the  
9 individual's sex assignment at birth."

10 SECTION 18. A new section of the Health Maintenance  
11 Organization Law is enacted to read:

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

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

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

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

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

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

4 SECTION 19. Section 59A-46-44 NMSA 1978 (being Laws  
5 2001, Chapter 14, Section 3, as amended) is amended to read:

6 "59A-46-44. COVERAGE FOR CONTRACEPTION.--

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

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

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

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

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

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1                   (5) United States food and drug  
2                   administration-approved, -cleared or -granted over-the-counter  
3                   contraception, including point-of-sale coverage for over-the-  
4                   counter contraception at in-network dispensing entities.

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

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

17                              [~~(4)~~] (5) any other restrictions or delays on  
18                   the coverage.

19                   C. A health maintenance organization may discourage  
20                   brand-name pharmacy drugs or items by applying cost sharing to  
21                   brand-name drugs or items when at least one generic or  
22                   therapeutic equivalent is covered within the same method of  
23                   contraception without patient cost sharing; provided that when  
24                   an enrollee's health care provider determines that a particular  
25                   drug or item is medically necessary, the individual or group

1 health maintenance organization contract shall cover the brand-  
2 name pharmacy drug or item without cost sharing. Medical  
3 necessity may include considerations such as severity of side  
4 effects, differences in permanence or reversibility of  
5 contraceptives and ability to adhere to the appropriate use of  
6 the drug or item, as determined by the attending provider.

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

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

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

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

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

25 F. An individual or group health maintenance

1 organization contract shall provide coverage and shall  
2 reimburse a health care provider or dispensing entity on a per-  
3 unit basis for dispensing a [~~six-month~~] twelve-month supply of  
4 contraceptives at one time; provided that the contraceptives  
5 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 individual or group health  
10 maintenance organization contract to limit coverage or impose  
11 cost sharing for an alternate method of contraception if an  
12 enrollee changes contraceptive methods before exhausting a  
13 previously dispensed supply.

14 H. A religious entity purchasing individual or  
15 group health maintenance organization coverage may elect to  
16 exclude prescription contraceptive drugs or devices from the  
17 health coverage purchased.

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

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

23 (2) a short-term travel, an accident-only, a  
24 hospital-indemnity-only, a limited-benefit or a specified  
25 disease health benefits [~~plans~~] plan.

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

4                   J. For the purposes of this section:

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

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

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

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

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

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1 business.

2 ~~[K. 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 SECTION 20. A new section of the Health Maintenance  
7 Organization Law is enacted to read:

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

9 A. An individual or group health maintenance  
10 organization contract delivered or issued for delivery in this  
11 state shall establish a special enrollment period to provide  
12 coverage to an uninsured person if the person is eligible to be  
13 insured and provides a certification from a health care  
14 provider to the insurer that the person is pregnant.

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

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

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

23 A. An individual or group health maintenance  
24 organization contract delivered or issued for delivery in this  
25 state shall provide coverage for the total cost of gender-

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1 affirming care. The coverage shall not be subject to cost-  
2 sharing provisions.

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

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

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

11 C. As used in this section:

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

16 (2) "gender-affirming care" means a procedure,  
17 service, drug, device or product that a physical or behavioral  
18 health care provider prescribes to treat an individual for  
19 incongruence between the individual's gender identity and the  
20 individual's sex assignment at birth."

21 SECTION 22. A new section of the Nonprofit Health Care  
22 Plan Law is enacted to read:

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

24 A. A health care plan delivered or issued for  
25 delivery in this state shall provide coverage for the total

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1 cost of abortion care that shall not be subject to cost-  
2 sharing provisions.

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

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

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

11 C. As used in this section, "cost sharing" means a  
12 deductible, copayment or coinsurance that a subscriber is  
13 required to pay in accordance with the terms of a health care  
14 plan."

15 SECTION 23. Section 59A-47-45.5 NMSA 1978 (being Laws  
16 2019, Chapter 263, Section 9) is amended to read:

17 "59A-47-45.5. COVERAGE FOR CONTRACEPTION.--

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

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

24 (2) a sufficient number and assortment of oral  
25 contraceptive pills to reflect the variety of oral

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1 contraceptives approved by the federal food and drug  
2 administration; ~~and~~]

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

8 (4) a sufficient quantity to allow for the  
9 continuous use of clinically appropriate contraception as  
10 determined by the prescribing provider; and

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

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

18 (1) cost sharing for subscribers;  
19 (2) utilization review;  
20 (3) prior authorization or step-therapy  
21 requirements; ~~or~~]

22 (4) quantity or fill limits if the practice  
23 would result in a subscriber receiving less than a twelve-  
24 months' duration of contraception dispensed either at one time  
25 or, if requested by the subscriber at the point of dispensing,



1 over a twelve-month period; or

2 [~~(4)~~] (5) any restrictions or delays on the  
3 coverage.

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

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

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

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

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

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

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

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

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

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

25 (3) permit a plan or pharmacy benefits manager

1 to:

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

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

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

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

14 (1) a high-deductible health benefit plan  
15 issued or renewed in this state until a subscriber's deductible  
16 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 [plans] plan.

20 ~~[I. The provisions of this section apply to health~~  
21 ~~care plans delivered or issued for delivery after January 1,~~  
22 ~~2020.]~~

23 J. For the purposes of this section:

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

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

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

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

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

20 ~~[K. A religious entity purchasing individual or~~  
21 ~~group health care plan coverage may elect to exclude~~  
22 ~~prescription contraceptive drugs or items from the health~~  
23 ~~insurance coverage purchased.]"~~

24 SECTION 24. A new section of the Nonprofit Health Care  
25 Plan Law is enacted to read:

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

2 A. A health care plan delivered or issued for  
3 delivery in this state shall establish a special enrollment  
4 period to provide coverage to an uninsured person if the person  
5 is eligible to be insured and provides a certification from a  
6 health care provider to the insurer that the person is  
7 pregnant.

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

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

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

16 A. A health care plan delivered or issued for  
17 delivery in this state shall provide coverage for the total  
18 cost of gender-affirming care. The coverage shall not be  
19 subject to cost-sharing provisions.

20 B. 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 subscriber's  
24 deductible has been met; or

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

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1 hospital-indemnity-only, a limited-benefit or a specified-  
2 disease health care plan.

3 C. As used in this section:

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

7 (2) "gender-affirming care" means a procedure,  
8 service, drug, device or product that a physical or behavioral  
9 health care provider prescribes to treat an individual for  
10 incongruence between the individual's gender identity and the  
11 individual's sex assignment at birth."

12 SECTION 26. APPLICABILITY.--The provisions of this act  
13 apply to policies, plans, contracts and certificates delivered  
14 or issued for delivery or renewed, extended or amended in this  
15 state beginning January 1, 2027.

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