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

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

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

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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;

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

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

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

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 insured is required to pay in accordance with the terms of group health coverage."

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

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

A. Except as provided in Subsection C of this section, 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 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 disease-specific group health plan.

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

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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.

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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, unless allowed pursuant to federal law; or

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

C. As used in this section:

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

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

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

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

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

(1) at least one product or form of

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

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

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

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

(1) enrollee cost sharing;

(2) utilization review;

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

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

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

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

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

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

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

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

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

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

F. A group health plan shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing [~~a six-month supply of contraceptives~~] contraception intended to last the insured for a duration of twelve months, as permitted by the insured'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 group health plan to limit coverage or impose cost sharing for an alternate method of contraception if an enrollee changes contraceptive methods before exhausting a previously dispensed supply.

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

(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

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

I. For the purposes of this section:

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

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

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

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

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

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

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;

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(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.--

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

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

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

D. As used in this section:

(1) "family planning services" means services

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

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

(a) abortion care;

(b) miscarriage management;

(c) medically necessary evaluations or preventive services, such as tobacco utilization screening, counseling, testing and cessation services;

(d) cervical cancer screening and prevention;

(e) prevention, diagnosis or treatment of a sexually transmitted infection or sexually transmitted disease; and

(f) mental health screening and referral."

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

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

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

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

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

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

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

"[NEW MATERIAL] LACTATION SUPPORT.--

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

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

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

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

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

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

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

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

B. Coverage provided pursuant to this section:

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

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

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

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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

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DRUGS OR DEVICES.--

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

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

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

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

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

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

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

(1) cost sharing for insureds;

(2) utilization review;

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

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

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

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

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

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

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

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

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

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

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

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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

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deductible has been met; or

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

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

J. For the purposes of this section:

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

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

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

(2) "cost sharing" means a deductible,

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

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

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

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

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

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 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 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

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the person makes a plan selection."

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

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

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 gender-affirming health 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:

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

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

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

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

A. A group or blanket 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 insured 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."

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

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

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

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

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

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

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

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

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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 insureds;

(2) utilization review;

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

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

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

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

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

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

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

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

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

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

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

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dispensing entity on a per unit basis for dispensing [~~a six-month supply of contraceptives~~] contraception intended to last the insured for a duration of twelve months, as permitted by the insured'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 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;

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

(c) 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 items from the health insurance coverage purchased.

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

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(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 benefits [~~plans~~] plan.

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

J. For the purposes of this section:

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

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

(b) does not mean a product that has

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been recalled for safety reasons or withdrawn from the market;

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

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

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

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

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

A. A group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state 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

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

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

A. A group or blanket 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 gender-affirming health 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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A. An individual or group health maintenance organization contract 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 enrollee'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 a contract."

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

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

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

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

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identified by the federal food and drug administration;

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

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

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

(5) United States food and drug administration-approved, -cleared or -granted over-the-counter 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) enrollee cost sharing;

(2) utilization review;

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

(4) quantity or fill limits if the practice

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

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

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

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

(1) be easily accessible, transparent,

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

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

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

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

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

G. Nothing in this section shall be construed to:

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

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

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previously dispensed supply.

H. A religious entity purchasing individual or group health maintenance organization 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 enrollee'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 benefits [~~plans~~] plan.

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

J. For the purposes of this section:

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

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

underscored material = new
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spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional contraceptive method categories approved by the federal food and drug administration; and

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

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

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

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

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

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

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

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

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

A. An individual or group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for the total cost of gender-affirming health 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 enrollee'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:

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

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

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

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

A. A health care plan delivered or issued for delivery in this state shall provide coverage for the total cost of abortion care that 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 subscriber'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 a subscriber is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~contraceptives~~] 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

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apply to:

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

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

J. For the purposes of this section:

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

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

(b) does not mean a product that has

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been recalled for safety reasons or withdrawn from the market;

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

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

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

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

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

A. A health care plan delivered or issued for delivery in this state 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."

underscored material = new
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SECTION 28. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. A health care plan delivered or issued for delivery in this state shall provide coverage for the total cost of gender-affirming health 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 subscriber'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:

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

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

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

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

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