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HOUSE BILL 301

**53RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2018**

INTRODUCED BY

Nate Gentry

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING NEW SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROVIDE FOR CANCER-RELATED COVERAGE; ENACTING A NEW SECTION OF THE NMSA 1978 TO REQUIRE THE SECRETARY OF HEALTH TO PROVIDE ANNUAL RECOMMENDATIONS RELATED TO CANCER-RELATED COVERAGE.

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

**SECTION 1.** [NEW MATERIAL] CANCER-RELATED COVERAGE-- SECRETARY OF HEALTH RECOMMENDATIONS.--By September 1, 2018 and each September 1 thereafter, the secretary of health shall review best practices in the prevention and detection of cancer in women and girls and make recommendations to the superintendent of insurance and the secretary of human services

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1 for the establishment of health coverage requirements under the  
2 Health Care Purchasing Act, the state's medicaid program and  
3 private health care coverage.

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

6 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--

7 A. Group health coverage, including any form of  
8 self-insurance, offered, issued or renewed under the Health  
9 Care Purchasing Act shall provide, at a minimum, the following  
10 coverage:

11 (1) low-dose screening mammograms for  
12 determining the presence of breast cancer. This coverage shall  
13 make available one baseline mammogram to enrollees thirty-five  
14 through thirty-nine years of age, one mammogram biennially to  
15 enrollees forty through forty-nine years of age and one  
16 mammogram annually to enrollees fifty years of age and over.  
17 This coverage shall be available only for screening mammograms  
18 obtained on equipment designed specifically to perform low-dose  
19 mammography in imaging facilities that have met American  
20 college of radiology accreditation standards for mammography;

21 (2) not less than forty-eight hours of  
22 inpatient care following a mastectomy and not less than  
23 twenty-four hours of inpatient care following a lymph node  
24 dissection for the treatment of breast cancer; provided that  
25 nothing in this paragraph shall be construed as requiring the

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1 provision of inpatient coverage where the attending physician  
2 and patient determine that a shorter period of hospital stay is  
3 appropriate;

4 (3) cytologic and human papillomavirus  
5 screening for determining the presence of precancerous or  
6 cancerous conditions and other health problems; provided that  
7 the coverage shall make available:

8 (a) cytologic screening, as determined  
9 by the health care provider in accordance with national medical  
10 standards, for female enrollees who are eighteen years of age  
11 or older and for female enrollees who are at risk of cancer or  
12 at risk of other health conditions that can be identified  
13 through cytologic screening; and

14 (b) human papillomavirus screening once  
15 every three years for female enrollees who are thirty years of  
16 age and older;

17 (4) the human papillomavirus vaccine to female  
18 enrollees nine to fourteen years of age;

19 (5) screening for cervical cancer every three  
20 years for female enrollees twenty-one to sixty-five years of  
21 age;

22 (6) for female enrollees who are at increased  
23 risk for breast cancer and at low risk for adverse medication  
24 effects, prescription drugs that reduce the risk of cancer; and

25 (7) any other screening for the prevention or

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1 detection of cancer in women that the secretary of health  
2 recommends.

3 B. The coverage required pursuant to this section  
4 shall not be subject to:

5 (1) enrollee cost-sharing;

6 (2) utilization review;

7 (3) prior authorization or step therapy  
8 requirements; or

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

11 C. By November 1, 2018 and each November 1  
12 thereafter, a group health plan administrator shall consult  
13 with the office of superintendent of insurance to learn current  
14 coverage guidelines for screening for the prevention or  
15 detection of cancer in women and girls adopted pursuant to the  
16 recommendations the secretary of health has issued pursuant to  
17 Paragraph (7) of Subsection A of this section.

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

23 (1) be easily accessible, transparent,  
24 sufficiently expedient and not unduly burdensome on an  
25 enrollee, the enrollee's representative or the enrollee's

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1 health care provider;

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

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

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

11 F. For the purposes of 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 a group health plan;

15 (2) "cytologic screening" means a Papanicolaou  
16 test and a pelvic exam for asymptomatic as well as symptomatic  
17 women;

18 (3) "health care provider" means any person  
19 authorized within the scope of the person's practice to provide  
20 the cancer-related services for which coverage is required  
21 pursuant to Subsection A of this section; and

22 (4) "human papillomavirus screening" means a  
23 test approved by the United States food and drug administration  
24 for detection of the human papillomavirus."

25 **SECTION 3.** A new section of the Public Assistance Act is

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1 enacted to read:

2 "[NEW MATERIAL] MEDICAL ASSISTANCE--CANCER PREVENTION AND  
3 EARLY DETECTION.--

4 A. The secretary shall ensure that, at a minimum, a  
5 medical assistance plan provides the following coverage to  
6 recipients:

7 (1) not less than forty-eight hours of  
8 inpatient care following a mastectomy and not less than  
9 twenty-four hours of inpatient care following a lymph node  
10 dissection for the treatment of breast cancer; provided that  
11 nothing in this paragraph shall be construed as requiring the  
12 provision of inpatient coverage where the attending physician  
13 and patient determine that a shorter period of hospital stay is  
14 appropriate;

15 (2) cytologic and human papillomavirus  
16 screening for determining the presence of precancerous or  
17 cancerous conditions and other health problems; provided that  
18 the coverage shall make available:

19 (a) cytologic screening, as determined  
20 by the health care provider in accordance with national medical  
21 standards, for female recipients who are eighteen years of age  
22 or older and for female recipients who are at risk of cancer or  
23 at risk of other health conditions that can be identified  
24 through cytologic screening; and

25 (b) human papillomavirus screening once

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1 every three years for female recipients who are thirty years of  
2 age and older;

3 (3) for female recipients who are at increased  
4 risk for breast cancer and at low risk for adverse medication  
5 effects, prescription drugs that reduce the risk of cancer;

6 (4) the human papillomavirus vaccine to female  
7 recipients nine to fourteen years of age;

8 (5) screening for cervical cancer every three  
9 years for female recipients twenty-one to sixty-five years of  
10 age; and

11 (6) any other screening for the prevention or  
12 detection of cancer in women that the secretary of health  
13 recommends.

14 B. The coverage required pursuant to this section  
15 shall not be subject to:

16 (1) recipient cost-sharing;

17 (2) utilization review;

18 (3) prior authorization or step therapy  
19 requirements; or

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

22 C. By November 1, 2018 and each November 1  
23 thereafter, the secretary shall adopt and promulgate any rules  
24 necessary to implement the coverage guidelines for screening  
25 for the prevention or detection of cancer in women and girls

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1 pursuant to the recommendations the secretary of health has  
2 issued pursuant to Paragraph (6) of Subsection A of this  
3 section.

4 D. A medical assistance plan shall grant a  
5 recipient an expedited hearing to appeal any adverse  
6 determination made relating to the coverage provisions of this  
7 section. The process for requesting an expedited hearing  
8 pursuant to this subsection shall:

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

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

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

19 E. For the purposes of this section:

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

23 (2) "cytologic screening" means a Papanicolaou  
24 test and a pelvic exam for asymptomatic as well as symptomatic  
25 women;

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1 (3) "health care provider" means any person  
2 authorized within the scope of the person's practice to provide  
3 the cancer-related services for which coverage is required  
4 pursuant to Subsection A of this section; and

5 (4) "human papillomavirus screening" means a  
6 test approved by the United States food and drug administration  
7 for detection of the human papillomavirus."

8 SECTION 4. A new section of Chapter 59A, Article 22 NMSA  
9 1978 is enacted to read:

10 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--

11 A. Each individual and group health insurance  
12 policy, health care plan and certificate of health insurance  
13 delivered or issued for delivery in this state shall provide,  
14 at a minimum, the following coverage:

15 (1) screening for cervical cancer every three  
16 years for female insureds twenty-one to sixty-five years of  
17 age;

18 (2) for female insureds who are at increased  
19 risk for breast cancer and at low risk for adverse medication  
20 effects, prescription drugs that reduce the risk of cancer; and

21 (3) any other screening for the prevention or  
22 detection of cancer in women that the secretary of health  
23 recommends.

24 B. The coverage required pursuant to this section  
25 shall not be subject to:

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- 1 (1) insured cost-sharing;  
2 (2) utilization review;  
3 (3) prior authorization or step therapy  
4 requirements; or  
5 (4) any other restrictions or delays on the  
6 coverage.

7 C. An insurer shall grant an insured an expedited  
8 hearing to appeal any adverse determination made relating to  
9 the coverage provisions of this section. The process for  
10 requesting an expedited hearing pursuant to this subsection  
11 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 D. The provisions of this section shall not apply  
23 to short-term travel, accident-only or limited or disease-  
24 specific health coverage.

25 E. For the purposes of this section:

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

5 (2) "health care provider" means any person  
6 authorized within the scope of the person's practice to provide  
7 the cancer-related services for which coverage is required  
8 pursuant to Subsection A of this section."

9 SECTION 5. A new section of Chapter 59A, Article 23 NMSA  
10 1978 is enacted to read:

11 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--

12 A. Each blanket or group health insurance policy,  
13 health care plan and certificate of health insurance delivered  
14 or issued for delivery in this state shall provide, at a  
15 minimum, the following coverage:

16 (1) screening for cervical cancer every three  
17 years for female insureds twenty-one to sixty-five years of  
18 age;

19 (2) for female insureds who are at increased  
20 risk for breast cancer and at low risk for adverse medication  
21 effects, prescription drugs that reduce the risk of cancer; and

22 (3) any other screening for the prevention or  
23 detection of cancer in women that the secretary of health  
24 recommends.

25 B. The coverage required pursuant to this section

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1 shall not be subject to:

- 2 (1) insured cost-sharing;
- 3 (2) utilization review;
- 4 (3) prior authorization or step therapy
- 5 requirements; or
- 6 (4) any other restrictions or delays on the
- 7 coverage.

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

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

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

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

23 D. The provisions of this section shall not apply  
24 to short-term travel, accident-only or limited or disease-  
25 specific health coverage.

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1 E. For the purposes of this section:

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

6 (2) "health care provider" means any person  
7 authorized within the scope of the person's practice to provide  
8 the cancer-related services for which coverage is required  
9 pursuant to Subsection A of this section."

10 SECTION 6. A new section of the Health Maintenance  
11 Organization Law is enacted to read:

12 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--

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, at a minimum, the  
16 following coverage:

17 (1) screening for cervical cancer every three  
18 years for female enrollees twenty-one to sixty-five years of  
19 age;

20 (2) for female enrollees who are at increased  
21 risk for breast cancer and at low risk for adverse medication  
22 effects, prescription drugs that reduce the risk of cancer; and

23 (3) any other screening for the prevention or  
24 detection of cancer in women that the secretary of health  
25 recommends.

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1           B. The coverage required pursuant to this section  
2 shall not be subject to:

- 3                   (1) enrollee cost-sharing;  
4                   (2) utilization review;  
5                   (3) prior authorization or step therapy  
6 requirements; or  
7                   (4) any other restrictions or delays on the  
8 coverage.

9           C. A carrier shall grant an enrollee an expedited  
10 hearing to appeal any adverse determination made relating to  
11 the coverage provisions of this section. The process for  
12 requesting an expedited hearing pursuant to this subsection  
13 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           D. The provisions of this section shall not apply  
25 to short-term travel, accident-only or limited or disease-

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1 specific health coverage.

2 E. For the purposes of this section:

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

7 (2) "health care provider" means any person  
8 authorized within the scope of the person's practice to provide  
9 the cancer-related services for which coverage is required  
10 pursuant to Subsection A of this section."

11 SECTION 7. A new section of the Nonprofit Health Care  
12 Plan Law is enacted to read:

13 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--

14 A. An individual or group health care plan that is  
15 delivered, issued for delivery or renewed in this state shall  
16 provide, at a minimum, the following coverage:

17 (1) low-dose screening mammograms for  
18 determining the presence of breast cancer. This coverage shall  
19 make available one baseline mammogram to subscribers thirty-  
20 five through thirty-nine years of age, one mammogram biennially  
21 to subscribers forty through forty-nine years of age and one  
22 mammogram annually to subscribers fifty years of age and over.  
23 This coverage shall be available only for screening mammograms  
24 obtained on equipment designed specifically to perform low-dose  
25 mammography in imaging facilities that have met American

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1 college of radiology accreditation standards for mammography;

2 (2) not less than forty-eight hours of  
3 inpatient care following a mastectomy and not less than  
4 twenty-four hours of inpatient care following a lymph node  
5 dissection for the treatment of breast cancer; provided that  
6 nothing in this paragraph shall be construed as requiring the  
7 provision of inpatient coverage where the attending physician  
8 and patient determine that a shorter period of hospital stay is  
9 appropriate;

10 (3) cytologic and human papillomavirus  
11 screening for determining the presence of precancerous or  
12 cancerous conditions and other health problems; provided that  
13 the coverage shall make available:

14 (a) cytologic screening, as determined  
15 by the health care provider in accordance with national medical  
16 standards, for female subscribers who are eighteen years of age  
17 or older and for female subscribers who are at risk of cancer  
18 or at risk of other health conditions that can be identified  
19 through cytologic screening; and

20 (b) human papillomavirus screening once  
21 every three years for female subscribers aged thirty and older;

22 (4) the human papillomavirus vaccine to female  
23 subscribers nine to fourteen years of age;

24 (5) screening for cervical cancer every three  
25 years for female subscribers twenty-one to sixty-five years of

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1 age;

2 (6) for female subscribers who are at  
3 increased risk for breast cancer and at low risk for adverse  
4 medication effects, prescription drugs that reduce the risk of  
5 cancer; and

6 (7) any other screening for the prevention or  
7 detection of cancer in women that the secretary of health  
8 recommends.

9 B. The coverage required pursuant to this section  
10 shall not be subject to:

11 (1) subscriber cost-sharing;

12 (2) utilization review;

13 (3) prior authorization or step therapy  
14 requirements; or

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

17 C. A health care plan shall grant a subscriber an  
18 expedited hearing to appeal any adverse determination made  
19 relating to the coverage provisions of this section. The  
20 process for requesting an expedited hearing pursuant to this  
21 subsection 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 D. The provisions of this section shall not apply  
8 to short-term travel, accident-only or limited or disease-  
9 specific health coverage.

10 E. For the purposes of this section:

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

14 (2) "cytologic screening" means a Papanicolaou  
15 test and a pelvic exam for asymptomatic as well as symptomatic  
16 women;

17 (3) "health care provider" means any person  
18 authorized within the scope of the person's practice to provide  
19 the cancer-related services for which coverage is required  
20 pursuant to Subsection A of this section; and

21 (4) "human papillomavirus screening" means a  
22 test approved by the United States food and drug administration  
23 for detection of the human papillomavirus."