HOUSE BILL 284

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

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AN ACT

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

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

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

"[NEW MATERIAL] COVERAGE FOR CONTRACEPTION.--

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

(1) at least one product or form of

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

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

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

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

(1) enrollee cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

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

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determines that a particular item or service is medically necessary, the group health plan shall cover the brand-name pharmacy item without cost-sharing. For the purposes of this subsection, "medically necessary" includes a health care provider's consideration of the following:

(1) severity of side effects;

(2) duration of efficacy; and

(3) other factors that the enrollee's health care provider deems relevant.

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

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

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

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

E. A group health plan shall not require a

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prescription for any 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 supply of contraceptives as follows; provided that the contraceptives are prescribed and self-administered:

(1) for the first fill of the contraceptive to an enrollee, a three-month supply, as prescribed; and

(2) for subsequent fills of the same contraceptive to the enrollee, regardless of whether the enrollee was enrolled in the group health plan at the time of the first fill for that contraceptive, a twelve-month supply, as prescribed.

G. Nothing in this section shall be construed to:

(1) require a health care provider to prescribe 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 short-term travel, accident-only or limited or disease-specific group health plans.

I. For the purposes of this section:

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(1) "contraceptive methods 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 methods of contraception approved by the federal food and drug administration; and

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

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

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

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

"[NEW MATERIAL] MEDICAL ASSISTANCE--REIMBURSEMENT FOR A TWELVE-MONTH SUPPLY OF COVERED PRESCRIPTION CONTRACEPTIVE DRUGS

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OR DEVICES.--

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

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

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

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

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

~~B. Coverage for food and drug administration-approved prescription contraceptive drugs or devices may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or~~

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~~certificate~~], at a minimum, the following coverage:

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

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

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

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

(1) cost-sharing for insureds;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

(4) any restrictions or delays on the coverage.

C. An insurer may discourage brand-name pharmacy items by applying cost-sharing to brand-name items when at least one generic or therapeutic equivalent is covered within

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the same method of contraception without cost-sharing by the insured; provided that when an insured's health care provider determines that a particular item or service is medically necessary, the health insurance policy, health care plan or certificate of health insurance shall cover the brand-name pharmacy item without cost-sharing. For the purposes of this subsection, "medically necessary" includes a health care provider's consideration of the following:

(1) severity of side effects;

(2) duration of efficacy; and

(3) other factors that the insured's health care provider deems relevant.

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

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involved for a claim involving an urgent health care need.

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

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

(1) for the first fill of the contraceptive to an insured, a three-month supply, as prescribed; and

(2) for subsequent fills of the same contraceptive to the insured, regardless of whether the insured was enrolled in coverage pursuant to the health insurance policy, health care plan or certificate of insurance at the time of the first fill for that contraceptive, a twelve-month supply, as prescribed.

G. Nothing in this section shall be construed to:

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

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

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

I. For the purposes of this section:

(1) "contraceptive methods 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 methods 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 insured is required to pay in accordance with the terms of a health insurance policy, health care plan or certificate of health insurance; and

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

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business.

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

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

"59A-46-44. COVERAGE FOR PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state that provides a prescription drug benefit shall provide [~~coverage for prescription contraceptive drugs or devices approved by the food and drug administration.~~

~~B. Coverage for food and drug administration-approved prescription contraceptive drugs or devices may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract~~], at a minimum, the following coverage:

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

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administration; and

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

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

(1) enrollee cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

(4) any restrictions or delays on the coverage.

C. A health maintenance organization may discourage brand-name pharmacy items by applying cost-sharing to brand-name items when at least one generic or therapeutic equivalent is covered within the same method of contraception without enrollee cost-sharing; provided that when an enrollee's health care provider determines that a particular item or service is medically necessary, the health maintenance organization shall cover the brand-name pharmacy item without cost-sharing. For the purposes of this subsection, "medically necessary" includes a health care provider's consideration of the following:

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(1) severity of side effects;

(2) duration of efficacy; and

(3) other factors that the enrollee's health care provider deems relevant.

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

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

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

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

E. A health maintenance organization contract shall not require a prescription for any item or service that is available without a prescription.

F. A 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 supply

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of contraceptives as follows; provided that the contraceptives are prescribed and self-administered:

(1) for the first fill of the contraceptive to an enrollee, a three-month supply, as prescribed; and

(2) for subsequent fills of the same contraceptive to the enrollee, regardless of whether the enrollee was enrolled in health coverage pursuant to the health maintenance organization contract at the time of the first fill for that contraceptive, a twelve-month supply, as prescribed.

G. Nothing in this section shall be construed to:

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

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

H. For the purposes of this section:

(1) "contraceptive methods 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;

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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 methods 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 health maintenance organization contract; and

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

[~~C.~~] I. 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."

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