SENATE BILL 508

57TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2025

INTRODUCED BY

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and Micaelita Debbie O'Malley and Mimi Stewart

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT AND THE NEW MEXICO INSURANCE CODE TO REQUIRE COVERAGE FOR CERTAIN SEXUAL, REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES; TO ELIMINATE COST SHARING FOR CERTAIN SEXUAL, REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES; AND TO ELIMINATE PRIOR AUTHORIZATION REQUIREMENTS FOR CERTAIN SEXUAL, REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES.

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

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

"[NEW MATERIAL] PREVENTIVE BENEFITS--NO COST SHARING.--Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act

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shall provide coverage for and shall not impose any cost-sharing requirements for:

A. 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;

B. 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;

C. 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

D. with respect to women, additional preventive care and screenings to those described in Subsection A of this section, as provided for in comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services."

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,

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offered, issued, amended, delivered or renewed under the Health Care Purchasing Act shall provide coverage for the total cost of abortion care.

B. The coverage shall not be subject to cost sharing.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in this state until an eligible insured's deductible has been met."

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 when the person 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:

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"[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING 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 gender-affirming care.

B. As used in this section, "gender-affirming care" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

C. The provisions of Subsection A of this section do not apply to 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."

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

(2) a sufficient number and assortment of oral

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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 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

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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 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 enrollee for a duration of twelve months, as permitted by the enrollee'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 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, hospital-indemnity-only, limited-benefit or disease-specific group health plans.

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;

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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 limit a recipient's freedom to choose or change the method of family planning to be used, regardless of whether the recipient

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has exhausted a previously dispensed supply of contraceptives.

C. Nothing in this section shall be construed to:

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

(2) permit the authority or a managed care organization to impose any restrictions or delays on coverage, including 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 covered person at the point of dispensing, over a twelve-month period;

(3) permit the authority or a managed care organization to limit coverage or impose cost sharing for an alternative method of contraception if a patient changes contraceptive methods before exhausting a previously dispensed supply of contraceptives;

(4) permit the authority or a managed care organization to limit the quantity of contraceptive drugs or devices dispensed; or

(5) permit the authority or a managed care organization to deny coverage for the continuous use of clinically appropriate contraception as determined by the prescribing provider.

D. For the purposes of this section, "self-administered contraceptive" means combined oral contraceptives;

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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.--

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, any intermediaries or any managed care organization shall reimburse the provider of those services.

B. As used in this section:

(1) "family-planning-related services" means any 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

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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; and

(2) "family planning services" means all services covered by the federal Title X family planning program, regardless of an individual's or a partner's age, sex or gender identity, including:

(a) all contraceptive method categories approved by the federal food and drug administration, including: 1) tubal ligation; 2) sterilization implant; 3) copper intrauterine device; 4) intrauterine device with progestin; 5) implantable rod; 6) contraceptive injection; 7) combined oral contraceptives; 8) extended or continuous use oral contraceptives; 9) progestin-only oral contraceptives; 10) patch; 11) vaginal ring; 12) diaphragm with spermicide; 13) sponge with spermicide; 14) cervical cap with spermicide; 15) male and female condoms; 16) spermicide alone; 17) vasectomy; 18) ulipristal acetate; and 19) levonorgestrel emergency contraception;

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(b) health care and counseling services focused on preventing, delaying or planning for a pregnancy;

(c) follow-up visits to evaluate or manage problems associated with contraceptive methods; and

(d) basic fertility services.

C. A recipient shall be permitted to obtain family planning services or family-planning-related services from any licensed health care provider, including a doctor of medicine, a doctor of osteopathy, a physician assistant, an advanced practice registered nurse or a certified midwife. The enrollment of a recipient in a managed care organization shall not restrict a recipient's choice of the licensed 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.

D. When abortion care services are provided in accordance with the Public Assistance Act, the authority, any intermediaries or any 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."

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

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"[NEW MATERIAL] LACTATION SUPPORT.--

A. The authority shall ensure that medical assistance coverage, including coverage provided by any managed care organizations, 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, low birth weight infants or with lactation complications. Access to multi-user loaned breast pumps shall be authorized by a health care provider."

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

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

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

B. Coverage provided pursuant to this section:

(1) may be subject to other general exclusions and limitations of medical assistance coverage, including

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

SECTION 10. 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.

B. The coverage shall not be subject to cost sharing.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in this state until an eligible insured's deductible has been met."

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

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"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, 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

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over-the-counter contraception at in-network dispensing entities without prior authorization, step therapy, utilization management or cost sharing.

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 other restrictions or delays on the coverage, including 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 covered person at the point of dispensing, over a twelve-month period.

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

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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 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 covered

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person for a duration of twelve months, as permitted by the covered person'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 limit coverage or impose cost sharing for an alternate method of contraception if an insured changes contraceptive methods before exhausting a previously dispensed supply;

(3) permit an insurer to limit the quantity of contraceptives dispensed based on the number of months left in the plan year; or

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

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified-disease policies.

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.

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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, 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

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group health insurance coverage may elect to exclude prescription contraceptive drugs or devices from the health coverage purchased."

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

"[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING 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 gender-affirming care.

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B. As used in this section, "gender-affirming care" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

C. The provisions of this section do not apply to a high deductible health benefit plan issued or renewed in this state until an eligible insured's deductible has been met."

SECTION 14. 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.

B. The coverage shall not be subject to cost sharing.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in this state until an eligible insured's deductible has been met."

SECTION 15. 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 contraception, including point-of-sale coverage for over-the-counter contraception at in-network dispensing entities without prior authorization, step therapy, utilization management or cost sharing.

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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) 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 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

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

G. Nothing in this section shall be construed to:

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

(2) permit an insurer 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;

(3) permit an insurer to limit the quantity of contraceptives dispensed based on the number of months left in the plan year; or

(4) permit an insurer to deny coverage for the continuous use of clinically appropriate contraception as determined by the prescribing provider.

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified-disease health benefits plans.

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

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

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"[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 when the person 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 17. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR GENDER-AFFIRMING 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 gender-affirming care.

B. As used in this section, "gender-affirming care" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

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C. The provisions of this section shall not apply to a high deductible health benefit plans issued or renewed in this state until an eligible insured's deductible has been met."

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

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

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.

B. The coverage shall not be subject to cost sharing.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in this state until an eligible insured's deductible has been met."

SECTION 19. 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 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

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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;

(4) 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 without prior authorization, step therapy, utilization management or cost sharing.

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;

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(3) prior authorization or step-therapy requirements; or

(4) any other restrictions or delays on the coverage, including 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 covered person at the point of dispensing, over a twelve-month period.

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

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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. 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 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 months of contraceptives at one time; or

(2) permit an individual or group health maintenance organization contract to limit coverage or impose

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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, hospital-indemnity-only, limited-benefit or specified disease health benefits plans.

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 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;

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(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 20. 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 when the person 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."

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

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

A. An individual or group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for gender-affirming care.

B. As used in this section, "gender-affirming care" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in this state until an eligible enrollee's deductible has been met."

SECTION 22. A new section of 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.

B. The coverage shall not be subject to cost sharing.

C. The provisions of this section shall not apply to a high deductible health benefit plan issued or renewed in

this state until an eligible insured's deductible has been met."

SECTION 23. 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 administation-approved, -cleared or -granted over-the-counter contraception,

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including point-of-sale coverage for over-the counter contraception at in-network dispensing entities without prior authorization, step therapy, utilization management or cost sharing.

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) any restrictions or delays on the coverage, including 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 covered person at the point of dispensing, over a twelve-month period.

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

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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. 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

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

(3) permit a plan or pharmacy benefits manager to limit the quantity of contraceptives dispensed based on the number of months left in the plan year; or

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

H. The provisions of this section shall not apply to short-term travel, accident-only, hospital-indemnity-only, limited-benefit or specified-disease health care plans.

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

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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, 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

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

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

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

A. A health care plan delivered or issued for delivery in this state shall provide coverage for gender-affirming care.

B. As used in this section, "gender-affirming care" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender

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identity and the individual's sex assignment at birth.

C. The provisions of this section shall not apply to a high deductible health benefit plans issued or renewed in this state until an eligible subscriber's deductible has been met."

SECTION 26. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2026.

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