

1 SENATE BILL 508

2 **57TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2025**

3 INTRODUCED BY

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10 AN ACT

11 RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE
12 HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT AND THE
13 NEW MEXICO INSURANCE CODE TO REQUIRE COVERAGE FOR CERTAIN
14 SEXUAL, REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES;
15 TO ELIMINATE COST SHARING FOR CERTAIN SEXUAL, REPRODUCTIVE AND
16 GENDER-AFFIRMING HEALTH CARE SERVICES; AND TO ELIMINATE PRIOR
17 AUTHORIZATION REQUIREMENTS FOR CERTAIN SEXUAL, REPRODUCTIVE AND
18 GENDER-AFFIRMING HEALTH CARE SERVICES.
19

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

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

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

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

3 A. items or services that have in effect a rating
4 of "A" or "B" in the current recommendations of the United
5 States preventive services task force;

6 B. immunizations that have in effect a
7 recommendation from the advisory committee on immunization
8 practices of the federal centers for disease control and
9 prevention, with respect to the insured for which immunization
10 is considered;

11 C. with respect to infants, children and
12 adolescents, preventive care and screenings provided for in the
13 comprehensive guidelines supported by the health resources and
14 services administration of the United States department of
15 health and human services; and

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

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

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

24 A. Except as provided in Subsection C of this
25 section, all group health coverage, including self-insurance,

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

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

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

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

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

13 A. Group health coverage, including self-insurance,
14 offered, issued, amended, delivered or renewed under the Health
15 Care Purchasing Act shall establish a special enrollment period
16 to provide coverage to an uninsured person when the person
17 provides a certification from a health care provider to the
18 insurer that the person is pregnant.

19 B. Coverage shall be effective before the end of
20 the first month in which the uninsured person receives
21 certification of the pregnancy, unless the person elects to
22 have coverage effective on the first day of the month following
23 the date that the person makes a plan selection."

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

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

2 A. All group health coverage, including self-
3 insurance, offered, issued, amended, delivered or renewed under
4 the Health Care Purchasing Act shall provide coverage for
5 gender-affirming care.

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

11 C. The provisions of Subsection A of this section
12 do not apply to a high deductible health benefit plan issued or
13 renewed in this state until an eligible insured's deductible
14 has been met, unless allowed pursuant to federal law."

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

17 "13-7-22. COVERAGE FOR CONTRACEPTION.--

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

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

25 (2) a sufficient number and assortment of oral

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1 contraceptive pills to reflect the variety of oral
2 contraceptives approved by the federal food and drug
3 administration; and

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

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

12 (1) enrollee cost sharing;

13 (2) utilization review;

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

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

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

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

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

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

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

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

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

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

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1 ~~contraceptives]~~ contraception intended to last the enrollee for
2 a duration of twelve months, as permitted by the enrollee's
3 prescription, dispensed at one time; provided that the
4 contraceptives are prescribed and self-administered.

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

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

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

12 H. The provisions of this section shall not apply
13 to short-term travel, accident-only, hospital-indemnity-only,
14 limited-benefit or disease-specific group health plans.

15 I. For the purposes of this section:

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

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

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

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

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

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

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

14 "27-2-12.29. MEDICAL ASSISTANCE--REIMBURSEMENT FOR A ONE-
15 YEAR SUPPLY OF COVERED PRESCRIPTION CONTRACEPTIVE DRUGS OR
16 DEVICES.--

17 A. In providing coverage for family planning
18 services and supplies under the medical assistance program, the
19 [department] authority shall ensure that a recipient is
20 permitted to fill or refill a prescription for a one-year
21 supply of a covered, self-administered contraceptive at one
22 time, as prescribed.

23 B. Nothing in this section shall be construed to
24 limit a recipient's freedom to choose or change the method of
25 family planning to be used, regardless of whether the recipient

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1 has exhausted a previously dispensed supply of contraceptives.

2 C. Nothing in this section shall be construed to:

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

5 (2) permit the authority or a managed care
6 organization to impose any restrictions or delays on coverage,
7 including quantity or fill limits, if the practice would result
8 in a covered person receiving less than a twelve-months'
9 duration of contraception dispensed either at one time or, if
10 requested by the covered person at the point of dispensing,
11 over a twelve-month period;

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

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

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

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

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1 extended or continuous use oral contraceptives; progestin-only
2 oral contraceptives; patch; vaginal ring; diaphragm with
3 spermicide; sponge with spermicide; cervical cap with
4 spermicide; male and female condoms; spermicide alone;
5 ulipristal acetate; levonorgestrel emergency contraception; and
6 any other self-administered contraceptive method categories
7 approved by the federal food and drug administration."

8 SECTION 7. A new section of the Public Assistance Act is
9 enacted to read:

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

11 A. When family planning services or family-
12 planning-related services are provided in accordance with the
13 Public Assistance Act, the authority shall authorize
14 reimbursement for services without quantity limitation,
15 utilization controls or prior authorization. The authority,
16 any intermediaries or any managed care organization shall
17 reimburse the provider of those services.

18 B. As used in this section:

19 (1) "family-planning-related services" means
20 any medical diagnosis, treatment or preventive service that is
21 routinely provided pursuant to a family planning visit,
22 including:

- 23 (a) abortion care;
- 24 (b) miscarriage management;
- 25 (c) medically necessary evaluations or

1 preventive services, such as tobacco utilization screening,
2 counseling, testing, and cessation services;

3 (d) cervical cancer screening and
4 prevention;

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

8 (f) mental health screening and
9 referral; and

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

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

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

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

5 (d) basic fertility services.

6 C. A recipient shall be permitted to obtain family
7 planning services or family-planning-related services from any
8 licensed health care provider, including a doctor of medicine,
9 a doctor of osteopathy, a physician assistant, an advanced
10 practice registered nurse or a certified midwife. The
11 enrollment of a recipient in a managed care organization shall
12 not restrict a recipient's choice of the licensed provider from
13 whom the recipient may receive those services or restrict the
14 obligation of the managed care organization to reimburse the
15 provider of those services.

16 D. When abortion care services are provided in
17 accordance with the Public Assistance Act, the authority, any
18 intermediaries or any managed care organization shall reimburse
19 the provider of those services as distinct, non-bundled
20 procedural services and shall allow modifier codes, including
21 increased professional service, distinct procedural services
22 and separate structures, to reflect the increased time and
23 training required when applicable."

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

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1 "[NEW MATERIAL] LACTATION SUPPORT.--

2 A. The authority shall ensure that medical
3 assistance coverage, including coverage provided by any managed
4 care organizations, provides coverage for lactation support,
5 including:

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

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

11 B. Access to multi-user loaned breast pumps shall
12 be prioritized for persons with premature, medically fragile,
13 low birth weight infants or with lactation complications.
14 Access to multi-user loaned breast pumps shall be authorized by
15 a health care provider."

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

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

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

23 B. Coverage provided pursuant to this section:

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

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1 coordination of benefits, participating provider requirements
2 and restrictions on services provided by family or household
3 members; and

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

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

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

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

14 A. An individual or group health insurance policy,
15 health care plan or certificate of health insurance that is
16 delivered, issued for delivery or renewed in this state shall
17 provide coverage for the total cost of abortion care.

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

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

24 SECTION 11. Section 59A-22-42 NMSA 1978 (being Laws
25 2001, Chapter 14, Section 1, as amended) is amended to read:

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1 "59A-22-42. COVERAGE FOR PRESCRIPTION CONTRACEPTIVE
2 DRUGS OR DEVICES.--

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

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

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

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

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

23 (5) United States food and drug
24 administration-approved, -cleared or -granted over-the-counter
25 contraception, including point-of-sale coverage for

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

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

- 7 (1) cost sharing for insureds;
8 (2) utilization review;
9 (3) prior authorization or step-therapy
10 requirements; or
11 (4) any other restrictions or delays on the
12 coverage, including quantity or fill limits if the practice
13 would result in a covered person receiving less than a
14 twelve-months' duration of contraception dispensed either at
15 one time or, if requested by the covered person at the point of
16 dispensing, over a twelve-month period.

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

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

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

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

13 (2) defer to the determination of the
14 insured'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. An insurer shall not require a prescription for
20 any drug, item or service that is available without a
21 prescription.

22 F. An insurer shall provide coverage and shall
23 reimburse a health care provider or dispensing entity on a per-
24 unit basis for dispensing ~~[a six-month supply of~~
25 ~~contraceptives]~~ contraception intended to last the covered

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1 person for a duration of twelve months, as permitted by the
2 covered person's prescription, dispensed at one time; provided
3 that the contraceptives are prescribed and self-administered.

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

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

8 (2) permit an insurer to limit coverage or
9 impose cost sharing for an alternate method of contraception if
10 an insured changes contraceptive methods before exhausting a
11 previously dispensed supply;

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

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

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

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

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1 J. For the purposes of this section:

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

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

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

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

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

25 K. A religious entity purchasing individual or

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

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

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

7 A. An individual or group health insurance policy,
8 health care plan or certificate of health insurance that is
9 delivered, issued for delivery or renewed in this state shall
10 establish a special enrollment period to provide coverage to an
11 uninsured person when the person provides a certification from
12 a health care provider to the insurer that the person is
13 pregnant.

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

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

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

22 A. An individual or group health insurance policy,
23 health care plan or certificate of health insurance that is
24 delivered, issued for delivery or renewed in this state shall
25 provide coverage for gender-affirming care.

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

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

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

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

12 A. A group or blanket health insurance policy,
13 health care plan or certificate of health insurance that is
14 delivered, issued for delivery or renewed in this state shall
15 provide coverage for the total cost of abortion care.

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

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

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

24 "59A-23-7.14. COVERAGE FOR CONTRACEPTION.--

25 A. ~~[Each individual and group]~~ A group or blanket

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1 health insurance policy, health care plan [~~and~~] or certificate
2 of health insurance that is delivered, [~~or~~] issued for delivery
3 or renewed in this state that provides a prescription drug
4 benefit shall provide, at a minimum, the following coverage:

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

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

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

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

20 (5) United States food and drug
21 administration-approved, -cleared or -granted over-the-counter
22 contraception, including point-of-sale coverage for
23 over-the-counter contraception at in-network dispensing
24 entities without prior authorization, step therapy, utilization
25 management or cost sharing.

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

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

10 C. An insurer may discourage brand-name pharmacy
11 drugs or items by applying cost sharing to brand-name drugs or
12 items when at least one generic or therapeutic equivalent is
13 covered within the same method category of contraception
14 without cost sharing by the insured; provided that when an
15 insured's health care provider determines that a particular
16 drug or item is medically necessary, the individual or group
17 health insurance policy, health care plan or certificate of
18 health insurance shall cover the brand-name pharmacy drug or
19 item without cost sharing. A determination of medical
20 necessity may include considerations such as severity of side
21 effects, differences in permanence or reversibility of
22 contraceptives and ability to adhere to the appropriate use of
23 the drug or item, as determined by the attending provider.

24 D. An insurer shall grant an insured an expedited
25 hearing to appeal any adverse determination made relating to

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1 the provisions of this section. The process for requesting an
2 expedited hearing pursuant to this subsection shall:

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

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

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

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

16 F. An individual or group health insurance policy,
17 health care plan or certificate of health insurance shall
18 provide coverage and shall reimburse a health care provider or
19 dispensing entity on a per unit basis for dispensing [~~a six-~~
20 ~~month supply of contraceptives~~] contraception intended to last
21 the covered person for a duration of twelve months, as
22 permitted by the covered person's prescription, dispensed at
23 one time; provided that the contraceptives are prescribed and
24 self-administered.

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

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

4 (2) permit an insurer to limit coverage or
5 impose cost sharing for an alternate method of contraception if
6 an insured changes contraceptive methods before exhausting a
7 previously dispensed supply;

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

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

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

17 I. The provisions of this section apply to
18 individual or group health insurance policies, health care
19 plans or certificates of insurance delivered or issued for
20 delivery after January 1, 2020.

21 J. For the purposes of this section:

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

24 (a) means tubal ligation; sterilization
25 implant; copper intrauterine device; intrauterine device with

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

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

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

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

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

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

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

2 A. A group or blanket health insurance policy,
3 health care plan or certificate of health insurance that is
4 delivered, issued for delivery or renewed in this state shall
5 establish a special enrollment period to provide coverage to an
6 uninsured person when the person provides a certification from
7 a health care provider to the insurer that the person is
8 pregnant.

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

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

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

17 A. A group or blanket health insurance policy,
18 health care plan or certificate of health insurance that is
19 delivered, issued for delivery or renewed in this state shall
20 provide coverage for gender-affirming care.

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

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

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

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

8 A. An individual or group health maintenance
9 organization contract that is delivered, issued for delivery or
10 renewed in this state shall provide coverage for the total cost
11 of abortion care.

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

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

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

20 "59A-46-44. COVERAGE FOR CONTRACEPTION.--

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

25 (1) at least one product or form of

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

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

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

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

15 (5) United States food and drug
16 administration-approved, -cleared or -granted over-the-counter
17 contraception, including point-of-sale coverage for
18 over-the-counter contraception at in-network dispensing
19 entities without prior authorization, step therapy, utilization
20 management or cost sharing.

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

24 (1) enrollee cost sharing;

25 (2) utilization review;

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

3 (4) any other restrictions or delays on the
4 coverage, including quantity or fill limits if the practice
5 would result in a covered person receiving less than a
6 twelve-months' duration of contraception dispensed either at
7 one time or, if requested by the covered person at the point of
8 dispensing, over a twelve-month period.

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

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

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1 expedited hearing pursuant to this subsection shall:

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

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

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

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

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

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

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

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

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1 cost sharing for an alternate method of contraception if an
2 enrollee changes contraceptive methods before exhausting a
3 previously dispensed supply.

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

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

10 J. For the purposes of this section:

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

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

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

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

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

8 K. A religious entity purchasing individual or
9 group health maintenance organization coverage may elect to
10 exclude prescription contraceptive drugs or devices from the
11 health coverage purchased."

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

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

15 A. An individual or group health maintenance
16 organization contract delivered or issued for delivery in this
17 state shall establish a special enrollment period to provide
18 coverage to an uninsured person when the person provides a
19 certification from a health care provider to the insurer that
20 the person is pregnant.

21 B. Coverage shall be effective before the end of
22 the first month in which the person receives certification of
23 the pregnancy, unless the person elects to have coverage
24 effective on the first day of the month following the date that
25 the person makes a plan selection."

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

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

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

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

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

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

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

19 A. A health care plan delivered or issued for
20 delivery in this state shall provide coverage for the total
21 cost of abortion care.

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

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

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

3 SECTION 23. Section 59A-47-45.5 NMSA 1978 (being Laws
4 2019, Chapter 263, Section 9) is amended to read:

5 "59A-47-45.5. COVERAGE FOR CONTRACEPTION.--

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

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

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

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

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

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

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

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

- 8 (1) cost sharing for subscribers;
9 (2) utilization review;
10 (3) prior authorization or step-therapy
11 requirements; or
12 (4) any restrictions or delays on the
13 coverage, including quantity or fill limits if the practice
14 would result in a covered person receiving less than a
15 twelve-months' duration of contraception dispensed either at
16 one time or, if requested by the covered person at the point of
17 dispensing, over a twelve-month period.

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

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1 cost sharing. A determination of medical necessity may include
2 considerations such as severity of side effects, differences in
3 permanence or reversibility of contraceptives and ability to
4 adhere to the appropriate use of the drug or item, as
5 determined by the attending provider.

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

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

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

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

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

24 F. A health care plan shall provide coverage and
25 shall reimburse a health care provider or dispensing entity on

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

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

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

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

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

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

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

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

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1 2020.

2 J. For the purposes of this section:

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

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

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

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

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

24 K. A religious entity purchasing individual or
25 group health care plan coverage may elect to exclude

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

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

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

6 A. A health care plan delivered or issued for
7 delivery in this state shall establish a special enrollment
8 period to provide coverage to an uninsured person when the
9 person provides a certification from a health care provider to
10 the insurer that the person is pregnant.

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

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

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

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

22 B. As used in this section, "gender-affirming care"
23 means a procedure, service, drug, device or product that a
24 physical or behavioral health care provider prescribes to treat
25 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.