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HOUSE BILL 504

**52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015**

INTRODUCED BY

Deborah A. Armstrong

AN ACT

RELATING TO HEALTH CARE; ENACTING A NEW SECTION OF THE PUBLIC ASSISTANCE ACT TO PROVIDE FOR CERTAIN MEDICAID COVERAGES; ENACTING A NEW SECTION OF THE NEW MEXICO INSURANCE CODE TO PROVIDE AN OPTION FOR CONFIDENTIALITY OF HEALTH CARE SERVICES; AMENDING AND ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE PREFERRED PROVIDER ARRANGEMENTS LAW, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ENSURE ACCESS TO CERTAIN HEALTH CARE SERVICES.

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

**SECTION 1.** Section 59A-22A-3 NMSA 1978 (being Laws 1993, Chapter 320, Section 61) is amended to read:

"59A-22A-3. DEFINITIONS.--As used in the Preferred Provider Arrangements Law:

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1           A. "contraceptive procedure" means any medically  
2 accepted procedure to prevent pregnancy;

3           B. "covered person" means any person on whose  
4 behalf the health care insurer is obligated to pay for or to  
5 provide health benefit services;

6           ~~[B.]~~ C. "covered services" means health care  
7 services ~~[which]~~ that the health care insurer is obligated to  
8 pay for or to provide under a health benefit plan;

9           ~~[C.]~~ D. "emergency care" means covered services  
10 delivered to a covered person after the sudden onset of a  
11 medical condition manifesting itself by acute symptoms that are  
12 severe enough that:

13                   (1) the lack of immediate medical attention  
14 could result in:

15                           (a) placing the person's health in  
16 jeopardy;

17                           (b) serious impairment of bodily  
18 functions; or

19                           (c) serious dysfunction of any bodily  
20 organ or part; or

21                   (2) a reasonable person believes that  
22 immediate medical attention is required;

23           E. "family planning services" means:

24                   (1) contraceptive procedures; and

25                   (2) diagnosis, supplies, follow-up services,

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1 social services and education related to reproductive health;

2 F. "gynecological services" means the provision of  
3 diagnostic and treatment services relating to the female  
4 reproductive system, including annual pelvic exams and pap  
5 smears, follow-up and outpatient treatment of abnormal findings  
6 and diagnosis and treatment of sexually transmitted infections,  
7 but not including family planning services;

8 [~~D-~~] G. "health benefit plan" means the health  
9 insurance policy or subscriber agreement between the covered  
10 person or the policyholder and the health care insurer which  
11 defines the covered services and benefit levels available;

12 [~~E-~~] H. "health care insurer" means any person who  
13 provides health insurance in this state. For the purposes of  
14 the Small Group Rate and Renewability Act, "carrier" or  
15 "insurer" includes a licensed insurance company, a licensed  
16 fraternal benefit society, a prepaid hospital or medical  
17 service plan, a health maintenance organization, a nonprofit  
18 health care organization, a multiple employer welfare  
19 arrangement or any other person providing a plan of health  
20 insurance subject to state insurance regulation;

21 [~~F-~~] I. "health care provider" means providers of  
22 health care services licensed as required in this state;

23 [~~G-~~] J. "health care services" means services  
24 rendered or products sold by a health care provider within the  
25 scope of the provider's license. The term includes hospital,

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1 medical, surgical, dental, vision and pharmaceutical services  
2 or products;

3 ~~[H.]~~ K. "preferred provider" means a health care  
4 provider or group of providers who have contracted with a  
5 health care insurer to provide specified covered services to a  
6 covered person; ~~[and]~~

7 ~~[I.]~~ L. "preferred provider arrangement" means a  
8 contract between or on behalf of the health care insurer and a  
9 preferred provider which complies with all the requirements of  
10 the Preferred Provider Arrangements Law; and

11 M. "pregnancy-related services" means the care and  
12 treatment of women in childbirth, during the period before and  
13 after delivery, and other services relating to or arising out  
14 of pregnancy."

15 SECTION 2. Section 59A-22A-4 NMSA 1978 (being Laws 1993,  
16 Chapter 320, Section 62) is amended to read:

17 "59A-22A-4. PREFERRED PROVIDER ARRANGEMENTS.--

18 A. Notwithstanding any provisions of law to  
19 contrary, any health care insurer may enter into preferred  
20 provider arrangements.

21 ~~[A.]~~ B. Such arrangements shall:

22 (1) establish the amount and manner of payment  
23 to the preferred provider. Such amount and manner of payment  
24 may include capitation payments for preferred providers;

25 (2) include mechanisms ~~[which]~~ that are

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1 designed to minimize the cost of the health benefit plan; for  
2 example:

3 (a) the review or control of utilization  
4 of health care services; or

5 (b) procedures for determining whether  
6 health care services rendered are medically necessary; ~~and~~

7 (3) assure reasonable access to covered  
8 services available under the preferred provider arrangement and  
9 an adequate number of preferred providers to render those  
10 services; and

11 (4) assure adequate access to breast and  
12 cervical cancer screening, family planning services,  
13 gynecological services and pregnancy-related services.

14 ~~[B.]~~ C. Such arrangements shall not unfairly deny  
15 health benefits for medically necessary covered services.

16 ~~[G.]~~ D. If an entity enters into a contract  
17 providing covered services with a health care provider, but is  
18 not engaged in activities ~~[which]~~ that would require it to be  
19 licensed as a health care insurer, such entity shall file with  
20 the superintendent information describing its activities, a  
21 description of the contract or agreement it has entered into  
22 with the health care providers and such other information as is  
23 required by the provisions of the Health Care Benefits  
24 Jurisdiction Act and any regulations promulgated under its  
25 authority. Employers who enter into contracts with health care

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1 providers for the exclusive benefit of their employees and  
2 dependents are subject to the Health Care Benefits Jurisdiction  
3 Act and are exempt from this requirement only to the extent  
4 required by federal law."

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

7 "59A-22-42. ACCESS TO FAMILY PLANNING SERVICES--  
8 OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR  
9 PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

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

16 B. ~~Coverage for food and drug administration-~~  
17 ~~approved prescription contraceptive drugs or devices may be~~  
18 ~~subject to deductibles and coinsurance consistent with those~~  
19 ~~imposed on other benefits under the same policy, plan or~~  
20 ~~certificate] shall provide coverage to female insureds for all  
21 of the following gynecological and obstetrical services and  
22 contraceptive methods:~~

23 (1) all contraceptive drugs, devices and other  
24 products approved by the federal food and drug administration,  
25 including any contraceptive drug, device or other product

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1 prescribed by an insured's health care provider; provided that:

2 (a) if the federal food and drug  
3 administration has approved one or more therapeutically  
4 equivalent versions of a contraceptive drug, device or product,  
5 a policy, plan or certificate shall not be required to cover  
6 all of the therapeutically equivalent versions, so long as at  
7 least one drug, device or product in its class is included and  
8 covered without cost-sharing; and

9 (b) if the covered therapeutically  
10 equivalent versions of a drug, device or product are not  
11 available or are deemed medically contraindicated by the  
12 insured's health care provider, a policy, plan or certificate  
13 shall provide coverage for an alternative therapeutically  
14 equivalent version of the contraceptive drug, device or product  
15 without cost-sharing;

16 (2) patient education and counseling on  
17 contraception;

18 (3) voluntary sterilization procedures;

19 (4) breast and cervical cancer screening;

20 (5) diagnostic and treatment services relating  
21 to the female reproductive system, including annual pelvic  
22 exams and pap smears, follow-up care and outpatient treatment  
23 of abnormal findings and diagnosis pursuant to those exams and  
24 pap smears;

25 (6) prenatal care, including regular checkups

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1 for pregnant women with diagnosis and treatment of any health  
2 challenges that arise during pregnancy while promoting healthy  
3 lifestyles in accordance with nationally recognized standards;

4 (7) pregnancy-related services, including care  
5 and treatment of women in childbirth, during the period before  
6 and after delivery, and other services related to or arising  
7 out of pregnancy; and

8 (8) follow-up services related to the drugs,  
9 devices, products and procedures covered pursuant to this  
10 subsection, including management of side effects, counseling  
11 for continued adherence, social services, education related to  
12 reproductive health and device insertion and removal.

13 B. Drugs, devices, products or services covered  
14 pursuant to Subsection A of this section shall not be subject  
15 to any prior authorization or step therapy requirement.

16 C. An individual or group health insurance policy,  
17 health care plan or certificate of health insurance delivered,  
18 issued for delivery or renewed in this state shall provide  
19 coverage for screening, diagnosis and treatment of sexually  
20 transmitted infections and human immunodeficiency virus for all  
21 insureds, and counseling services for those insureds whom a  
22 health care provider deems to be at increased risk of  
23 infection.

24 D. An individual or group health insurance policy,  
25 health care plan or certificate of health insurance shall not

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1 impose a deductible, coinsurance, copayment or any other cost-  
2 sharing on the following coverages provided pursuant to this  
3 section:

- 4 (1) contraceptive drugs, devices or products;
- 5 (2) breast or cervical cancer screening;
- 6 (3) prenatal care; or
- 7 (4) sexually transmitted infection screening  
8 and counseling.

9 ~~[G-]~~ E. The provisions of this section shall not  
10 apply to short-term travel, accident-only or limited or  
11 specified-disease policies except for those policies providing  
12 coverage expressly for reproductive services.

13 ~~[D-]~~ F. A religious entity purchasing individual or  
14 group health insurance coverage may elect to exclude  
15 prescription contraceptive drugs or devices from the health  
16 coverage purchased."

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

19 "59A-46-44. ACCESS TO FAMILY PLANNING SERVICES--  
20 OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR  
21 PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

22 A. Each individual and group health maintenance  
23 organization contract delivered or issued for delivery in this  
24 state that provides a prescription drug benefit shall provide  
25 coverage [~~for prescription contraceptive drugs or devices~~

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1 ~~approved by the food and drug administration.~~

2 ~~B. Coverage for food and drug administration-~~  
3 ~~approved prescription contraceptive drugs or devices may be~~  
4 ~~subject to deductibles and coinsurance consistent with those~~  
5 ~~imposed on other benefits under the same contract] to female~~  
6 enrollees for all of the following gynecological and  
7 obstetrical services and contraceptive methods:

8 (1) all contraceptive drugs, devices and other  
9 products approved by the federal food and drug administration,  
10 including any contraceptive drug, device or other product  
11 prescribed by an enrollee's health care provider; provided  
12 that:

13 (a) if the federal food and drug  
14 administration has approved one or more therapeutically  
15 equivalent versions of a contraceptive drug, device or product,  
16 a health maintenance organization shall not be required to  
17 cover all of the therapeutically equivalent versions, so long  
18 as at least one drug, device or product in its class is  
19 included and covered without cost-sharing; and

20 (b) if the covered therapeutically  
21 equivalent versions of a drug, device or product are not  
22 available or are deemed medically contraindicated by the  
23 enrollee's health care provider, a health maintenance  
24 organization shall provide coverage for an alternative  
25 therapeutically equivalent version of the contraceptive drug,

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1 device or product without cost-sharing;

2 (2) patient education and counseling on  
3 contraception;

4 (3) voluntary sterilization procedures;

5 (4) breast and cervical cancer screening;

6 (5) diagnostic and treatment services relating  
7 to the female reproductive system, including annual pelvic  
8 exams and pap smears, follow-up care and outpatient treatment  
9 of abnormal findings and diagnosis pursuant to those exams and  
10 pap smears;

11 (6) prenatal care, including regular checkups  
12 for pregnant women with diagnosis and treatment of any health  
13 challenges that arise during pregnancy while promoting healthy  
14 lifestyles in accordance with nationally recognized standards;

15 (7) pregnancy-related services, including care  
16 and treatment of women in childbirth, during the period before  
17 and after delivery, and other services related to or arising  
18 out of pregnancy; and

19 (8) follow-up services related to the drugs,  
20 devices, products and procedures covered pursuant to this  
21 subsection, including management of side effects, counseling  
22 for continued adherence, social services, education related to  
23 reproductive health and device insertion and removal.

24 B. Drugs, devices, products or services covered  
25 pursuant to Subsection A of this section shall not be subject

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1 to any prior authorization or step therapy requirement.

2 C. An individual or group contract that is  
3 delivered, issued for delivery or renewed in this state shall  
4 provide coverage for screening, diagnosis and treatment of  
5 sexually transmitted infections and human immunodeficiency  
6 virus for all enrollees, and counseling services for those  
7 enrollees whom a health care provider deems to be at increased  
8 risk of infection.

9 D. A health maintenance organization shall not  
10 impose a deductible, coinsurance, copayment or any other cost-  
11 sharing on the following coverages provided pursuant to this  
12 section:

13 (1) contraceptive drugs, devices or products;  
14 (2) breast or cervical cancer screening;  
15 (3) prenatal care; or  
16 (4) sexually transmitted infection screening  
17 and counseling.

18 E. The provisions of this section shall not apply  
19 to short-term travel, accident-only or limited or  
20 specified-disease contracts, plans or policies, except for  
21 those contracts, plans or policies providing coverage expressly  
22 for reproductive services.

23 ~~[G.]~~ F. A religious entity purchasing individual or  
24 group health maintenance organization coverage may elect to  
25 exclude prescription contraceptive drugs or devices from the

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1 health coverage purchased."

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

4 "[NEW MATERIAL] ACCESS TO FAMILY PLANNING SERVICES--  
5 OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR  
6 PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

7 A. Group health coverage, including any form of  
8 self-insurance, offered, issued or renewed under the Health  
9 Care Purchasing Act shall provide coverage to female enrollees  
10 for all of the following gynecological and obstetrical services  
11 and contraceptive methods:

12 (1) all contraceptive drugs, devices and other  
13 products approved by the federal food and drug administration,  
14 including any contraceptive drug, device or other product  
15 prescribed by an enrollee's health care provider; provided  
16 that:

17 (a) if the federal food and drug  
18 administration has approved one or more therapeutically  
19 equivalent versions of a contraceptive drug, device or product,  
20 a group health plan shall not be required to cover all of the  
21 therapeutically equivalent versions, so long as at least one  
22 drug, device or product in its class is included and covered  
23 without cost-sharing; and

24 (b) if the covered therapeutically  
25 equivalent versions of a drug, device or product are not

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1 available or are deemed medically contraindicated by the  
2 enrollee's health care provider, a group health plan shall  
3 provide coverage for an alternative therapeutically equivalent  
4 version of the contraceptive drug, device or product without  
5 cost-sharing;

6 (2) patient education and counseling on  
7 contraception;

8 (3) voluntary sterilization procedures;

9 (4) breast and cervical cancer screening;

10 (5) diagnostic and treatment services relating  
11 to the female reproductive system, including annual pelvic  
12 exams and pap smears, follow-up care and outpatient treatment  
13 of abnormal findings and diagnosis pursuant to those exams and  
14 pap smears;

15 (6) prenatal care, including regular checkups  
16 for pregnant women with diagnosis and treatment of any health  
17 challenges that arise during pregnancy while promoting healthy  
18 lifestyles in accordance with nationally recognized standards;

19 (7) pregnancy-related services, including care  
20 and treatment of women in childbirth, during the period before  
21 and after delivery, and other services related to or arising  
22 out of pregnancy; and

23 (8) follow-up services related to the drugs,  
24 devices, products and procedures covered pursuant to this  
25 subsection, including management of side effects, counseling

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1 for continued adherence, social services, education related to  
2 reproductive health and device insertion and removal.

3 B. Drugs, devices, products or services covered  
4 pursuant to Subsection A of this section shall not be subject  
5 to any prior authorization or step therapy requirement.

6 C. A group health plan shall provide coverage for  
7 screening, diagnosis and treatment of sexually transmitted  
8 infections and human immunodeficiency virus for all enrollees,  
9 and counseling services for those enrollees whom a health care  
10 provider deems to be at increased risk of infection.

11 D. A group health plan shall not impose a  
12 deductible, coinsurance, copayment or any other cost-sharing on  
13 the following coverages provided pursuant to this section:

- 14 (1) contraceptive drugs, devices or products;  
15 (2) breast or cervical cancer screening;  
16 (3) prenatal care; or  
17 (4) sexually transmitted infection screening  
18 and counseling.

19 E. The provisions of this section shall not apply  
20 to short-term travel, accident-only or limited or specified-  
21 disease policies except for those policies providing coverage  
22 expressly for reproductive services."

23 SECTION 6. A new section of the Public Assistance Act is  
24 enacted to read:

25 "[NEW MATERIAL] MEDICAID--ELIGIBILITY FOR FAMILY PLANNING  
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1 SERVICES--ACCESS TO FAMILY PLANNING SERVICES--OBSTETRICAL  
2 SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR PRESCRIPTION  
3 CONTRACEPTIVE DRUGS OR DEVICES.--The secretary shall adopt and  
4 promulgate rules, in accordance with federal law, to ensure  
5 that:

6 A. family planning medicaid coverage is provided to  
7 applicants and reapplicants who:

8 (1) are eligible on the basis of household  
9 income as determined in accordance with the same financial  
10 eligibility criteria as those eligibility criteria promulgated  
11 for medicaid pregnancy services coverage;

12 (2) are otherwise eligible for family planning  
13 medicaid coverage in accordance with federal law; and

14 (3) comply with procedures for applying and  
15 maintaining eligibility in accordance with department rules;

16 B. medicaid coverage includes coverage to female  
17 recipients for all of the following gynecological and  
18 obstetrical services and contraceptive methods:

19 (1) all contraceptive drugs, devices and other  
20 products approved by the federal food and drug administration,  
21 including any contraceptive drug, device or other product  
22 prescribed by a recipient's health care provider, regardless of  
23 whether the drug, device or other product is available over the  
24 counter or by prescription only; provided that:

25 (a) if the federal food and drug

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1 administration has approved one or more therapeutically  
2 equivalent versions of a contraceptive drug, device or product,  
3 a group health plan shall not be required to cover all of the  
4 therapeutically equivalent versions, so long as at least one  
5 drug, device or product in its class is included and covered  
6 without cost-sharing; and

7 (b) if the covered therapeutically  
8 equivalent versions of a drug, device or product are not  
9 available or are deemed medically contraindicated by the  
10 recipient's health care provider, a group health plan shall  
11 provide coverage for an alternative therapeutically equivalent  
12 version of the contraceptive drug, device or product without  
13 cost-sharing;

14 (2) patient education and counseling on  
15 contraception;

16 (3) voluntary sterilization procedures;

17 (4) breast and cervical cancer screening;

18 (5) diagnostic and treatment services relating  
19 to the female reproductive system, including annual pelvic  
20 exams and pap smears, follow-up care and outpatient treatment  
21 of abnormal findings and diagnosis pursuant to those exams and  
22 pap smears;

23 (6) prenatal care, including regular checkups  
24 for pregnant women with diagnosis and treatment of any health  
25 challenges that arise during pregnancy while promoting healthy

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1 lifestyles in accordance with nationally recognized standards;

2 (7) pregnancy-related services, including care  
3 and treatment of women in childbirth, during the period before  
4 and after delivery, and other services related to or arising  
5 out of pregnancy; and

6 (8) follow-up services related to the drugs,  
7 devices, products and procedures covered pursuant to this  
8 subsection, including management of side effects, counseling  
9 for continued adherence, social services, education related to  
10 reproductive health and device insertion and removal;

11 C. drugs, devices, products or services covered  
12 pursuant to Subsection B of this section shall not be subject  
13 to any prior authorization or step therapy requirement;

14 D. medicaid coverage includes coverage for  
15 screening, diagnosis and treatment of sexually transmitted  
16 infections and human immunodeficiency virus for all recipients,  
17 and counseling services for those recipients whom a health care  
18 provider deems to be at increased risk of infection; and

19 E. medicaid does not impose a deductible,  
20 coinsurance, copayment or any other cost-sharing on the  
21 following coverages provided pursuant to this section:

- 22 (1) contraceptive drugs, devices or products;  
23 (2) breast or cervical cancer screening;  
24 (3) prenatal care; or  
25 (4) sexually transmitted infection screening

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1 and counseling."

2 SECTION 7. A new section of Chapter 59A, Article 23 NMSA  
3 1978 is enacted to read:

4 "[NEW MATERIAL] ACCESS TO FAMILY PLANNING SERVICES--  
5 OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR  
6 PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

7 A. A blanket or group health policy, health care  
8 plan or certificate of health insurance that is delivered,  
9 issued for delivery or renewed in this state shall provide  
10 coverage to female insureds for all of the following  
11 gynecological and obstetrical services and contraceptive  
12 methods:

13 (1) all contraceptive drugs, devices and other  
14 products approved by the federal food and drug administration,  
15 including any contraceptive drug, device or other product  
16 prescribed by an insured's health care provider; provided that:

17 (a) if the federal food and drug  
18 administration has approved one or more therapeutically  
19 equivalent versions of a contraceptive drug, device or product,  
20 a policy, plan or certificate shall not be required to cover  
21 all of the therapeutically equivalent versions, so long as at  
22 least one drug, device or product in its class is included and  
23 covered without cost-sharing; and

24 (b) if the covered therapeutically  
25 equivalent versions of a drug, device or product are not

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1 available or are deemed medically contraindicated by the  
2 insured's health care provider, a policy, plan or certificate  
3 shall provide coverage for an alternative therapeutically  
4 equivalent version of the contraceptive drug, device or product  
5 without cost-sharing;

6 (2) patient education and counseling on  
7 contraception;

8 (3) voluntary sterilization procedures;

9 (4) breast and cervical cancer screening;

10 (5) diagnostic and treatment services relating  
11 to the female reproductive system, including annual pelvic  
12 exams and pap smears, follow-up care and outpatient treatment  
13 of abnormal findings and diagnosis pursuant to those exams and  
14 pap smears;

15 (6) prenatal care, including regular checkups  
16 for pregnant women with diagnosis and treatment of any health  
17 challenges that arise during pregnancy while promoting healthy  
18 lifestyles in accordance with nationally recognized standards;

19 (7) pregnancy-related services, including care  
20 and treatment of women in childbirth, during the period before  
21 and after delivery, and other services related to or arising  
22 out of pregnancy; and

23 (8) follow-up services related to the drugs,  
24 devices, products and procedures covered pursuant to this  
25 subsection, including management of side effects, counseling

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1 for continued adherence, social services, education related to  
2 reproductive health and device insertion and removal.

3 B. Drugs, devices, products or services covered  
4 pursuant to Subsection A of this section shall not be subject  
5 to any prior authorization or step therapy requirement.

6 C. A blanket or group health policy, health care  
7 plan or certificate of health insurance delivered, issued for  
8 delivery or renewed in this state shall provide coverage for  
9 screening, diagnosis and treatment of sexually transmitted  
10 infections and human immunodeficiency virus for all insureds,  
11 and counseling services for those insureds whom a health care  
12 provider deems to be at increased risk of infection.

13 D. A blanket or group health policy, health care  
14 plan or certificate of health insurance shall not impose a  
15 deductible, coinsurance, copayment or any other cost-sharing on  
16 the following coverages provided pursuant to this section:

17 (1) contraceptive drugs, devices or products;  
18 (2) breast or cervical cancer screening;  
19 (3) prenatal care; or  
20 (4) sexually transmitted infection screening  
21 and counseling.

22 E. The provisions of this section shall not apply  
23 to short-term travel, accident-only or limited or specified-  
24 disease policies except for those policies providing coverage  
25 expressly for reproductive services."

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1           SECTION 8. A new section of the Nonprofit Health Care  
2 Plan Law is enacted to read:

3           "[NEW MATERIAL] ACCESS TO FAMILY PLANNING SERVICES--  
4 OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR  
5 PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--

6           A. An individual or group health care plan that is  
7 delivered, issued for delivery or renewed in this state shall  
8 provide coverage to female subscribers for all of the following  
9 gynecological and obstetrical services and contraceptive  
10 methods:

11                   (1) all contraceptive drugs, devices and other  
12 products approved by the federal food and drug administration,  
13 including any contraceptive drug, device or other product  
14 prescribed by a subscriber's health care provider; provided  
15 that:

16                           (a) if the federal food and drug  
17 administration has approved one or more therapeutically  
18 equivalent versions of a contraceptive drug, device or product,  
19 a plan shall not be required to cover all of the  
20 therapeutically equivalent versions, so long as at least one  
21 drug, device or product in its class is included and covered  
22 without cost-sharing; and

23                           (b) if the covered therapeutically  
24 equivalent versions of a drug, device or product are not  
25 available or are deemed medically contraindicated by the

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1 subscriber's health care provider, a plan shall provide  
2 coverage for an alternative therapeutically equivalent version  
3 of the contraceptive drug, device or product without cost-  
4 sharing;

5 (2) patient education and counseling on  
6 contraception;

7 (3) voluntary sterilization procedures;

8 (4) breast and cervical cancer screening;

9 (5) diagnostic and treatment services relating  
10 to the female reproductive system, including annual pelvic  
11 exams and pap smears, follow-up care and outpatient treatment  
12 of abnormal findings and diagnosis pursuant to those exams and  
13 pap smears;

14 (6) prenatal care, including regular checkups  
15 for pregnant women with diagnosis and treatment of any health  
16 challenges that arise during pregnancy while promoting healthy  
17 lifestyles in accordance with nationally recognized standards;

18 (7) pregnancy-related services, including care  
19 and treatment of women in childbirth, during the period before  
20 and after delivery, and other services related to or arising  
21 out of pregnancy; and

22 (8) follow-up services related to the drugs,  
23 devices, products and procedures covered pursuant to this  
24 subsection, including management of side effects, counseling  
25 for continued adherence, social services, education related to

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1 reproductive health and device insertion and removal.

2 B. Drugs, devices, products or services covered  
3 pursuant to Subsection A of this section shall not be subject  
4 to any prior authorization or step therapy requirement.

5 C. An individual or group health care plan shall  
6 provide coverage for screening, diagnosis and treatment of  
7 sexually transmitted infections and human immunodeficiency  
8 virus for all subscribers, and counseling services for those  
9 subscribers whom a health care provider deems to be at  
10 increased risk of infection.

11 D. An individual or group health care plan shall  
12 not impose a deductible, coinsurance, copayment or any other  
13 cost-sharing on the following coverages provided pursuant to  
14 this section:

- 15 (1) contraceptive drugs, devices or products;  
16 (2) breast or cervical cancer screening;  
17 (3) prenatal care; or  
18 (4) sexually transmitted infection screening  
19 and counseling.

20 E. The provisions of this section shall not apply  
21 to short-term travel, accident-only or limited or specified-  
22 disease policies or plans except for those policies providing  
23 coverage expressly for reproductive services."

24 SECTION 9. A new section of the New Mexico Insurance Code  
25 is enacted to read:

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1           "[NEW MATERIAL] CONFIDENTIALITY--HEALTH CARE SERVICES.--

2           A. The superintendent shall adopt and promulgate  
3 rules pursuant to which an insured shall have the option of  
4 formally notifying the insured's carrier that the insured does  
5 not authorize disclosure of any information relating to health  
6 care services that the insured receives to a third party. Upon  
7 receipt of this notification in accordance with office of  
8 superintendent of insurance rules, information relating to  
9 health care services that the insured has received shall be  
10 deemed confidential and shall be exempt from any provision of  
11 law granting access by any third party to this information,  
12 except for communications made pursuant to Section 27-1-8 or  
13 32A-4-3 NMSA 1978. This information includes:

- 14                   (1) billing for services;  
15                   (2) an explanation of a claim approved or  
16 denied;  
17                   (3) verification of a claim;  
18                   (4) the nature of the health care services  
19 received;  
20                   (5) the place or time of the health care  
21 services; and  
22                   (6) payment by any party for the claim.

23           B. As used in this section, "plan administrator"  
24 means a person that receives any form of administrative or  
25 service fee, consideration, payment, premium reimbursement or

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underscoring material = new  
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1 compensation for performing or providing any service, function  
2 or duty, or activity respecting insurance or alternatives to  
3 insurance in any administrative or management capacity,  
4 including claims or expense review, underwriting,  
5 administration and management under a contract or other  
6 agreement to be performed in this state or with respect to  
7 risks located or partially located in this state or on behalf  
8 of persons in this state for any third party except a third  
9 party that self-insures."

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