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:

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

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

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

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

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

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

(b) serious impairment of bodily functions; or

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

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

E. "family planning services" means:

(1) contraceptive procedures; and

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

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social services and education related to reproductive health;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"59A-22-42. ACCESS TO FAMILY PLANNING SERVICES--OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--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 or renewed in this state [~~that provides a prescription drug benefit shall provide coverage for prescription contraceptive drugs or devices approved by the food and drug administration.~~

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

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

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

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

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

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

(6) prenatal care, including regular checkups

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

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

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

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

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

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening and counseling.

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

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

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

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

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

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

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

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

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

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

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device or product without cost-sharing;

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

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

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

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

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

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to any prior authorization or step therapy requirement.

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening and counseling.

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

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

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health coverage purchased."

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

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

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

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

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

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

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

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

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

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

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

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

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

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening and counseling.

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

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

"[NEW MATERIAL] MEDICAID--ELIGIBILITY FOR FAMILY PLANNING

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SERVICES--ACCESS TO FAMILY PLANNING SERVICES--OBSTETRICAL SERVICES--GYNECOLOGICAL SERVICES--COVERAGE FOR PRESCRIPTION CONTRACEPTIVE DRUGS OR DEVICES.--The secretary shall adopt and promulgate rules, in accordance with federal law, to ensure that:

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

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

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

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

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

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

(a) if the federal food and drug

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

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

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

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

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lifestyles in accordance with nationally recognized standards;

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

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

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

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening

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and counseling."

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

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

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

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

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

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

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

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

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

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

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

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

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

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening and counseling.

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

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

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

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

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

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

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

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

(2) patient education and counseling on contraception;

(3) voluntary sterilization procedures;

(4) breast and cervical cancer screening;

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

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

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

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

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reproductive health and device insertion and removal.

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

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

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

(1) contraceptive drugs, devices or products;

(2) breast or cervical cancer screening;

(3) prenatal care; or

(4) sexually transmitted infection screening and counseling.

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

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

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

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

(1) billing for services;

(2) an explanation of a claim approved or denied;

(3) verification of a claim;

(4) the nature of the health care services received;

(5) the place or time of the health care services; and

(6) payment by any party for the claim.

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

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

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