HOUSE BILL 301

53RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2018

INTRODUCED BY

Nate Gentry

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING NEW SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROVIDE FOR CANCER-RELATED COVERAGE; ENACTING A NEW SECTION OF THE NMSA 1978 TO REQUIRE THE SECRETARY OF HEALTH TO PROVIDE ANNUAL RECOMMENDATIONS RELATED TO CANCER-RELATED COVERAGE.

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

SECTION 1. [NEW MATERIAL] CANCER-RELATED COVERAGE--SECRETARY OF HEALTH RECOMMENDATIONS.--By September 1, 2018 and each September 1 thereafter, the secretary of health shall review best practices in the prevention and detection of cancer in women and girls and make recommendations to the superintendent of insurance and the secretary of human services

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for the establishment of health coverage requirements under the Health Care Purchasing Act, the state's medicaid program and private health care coverage.

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

"[NEW MATERIAL] CANCER-RELATED COVERAGE.--

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

(1) low-dose screening mammograms for determining the presence of breast cancer. This coverage shall make available one baseline mammogram to enrollees thirty-five through thirty-nine years of age, one mammogram biennially to enrollees forty through forty-nine years of age and one mammogram annually to enrollees fifty years of age and over. This coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography;

(2) not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer; provided that nothing in this paragraph shall be construed as requiring the

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provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate;

(3) cytologic and human papillomavirus screening for determining the presence of precancerous or cancerous conditions and other health problems; provided that the coverage shall make available:

(a) cytologic screening, as determined by the health care provider in accordance with national medical standards, for female enrollees who are eighteen years of age or older and for female enrollees who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening; and

(b) human papillomavirus screening once every three years for female enrollees who are thirty years of age and older;

(4) the human papillomavirus vaccine to female enrollees nine to fourteen years of age;

(5) screening for cervical cancer every three years for female enrollees twenty-one to sixty-five years of age;

(6) for female enrollees who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer; and

(7) any other screening for the prevention or

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detection of cancer in women that the secretary of health recommends.

B. The coverage required pursuant to this section shall not be subject to:

(1) enrollee cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

C. By November 1, 2018 and each November 1 thereafter, a group health plan administrator shall consult with the office of superintendent of insurance to learn current coverage guidelines for screening for the prevention or detection of cancer in women and girls adopted pursuant to the recommendations the secretary of health has issued pursuant to Paragraph (7) of Subsection A of this section.

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

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

health care provider;

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

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

E. The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-specific group health plans.

F. For the purposes of this section:

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

(2) "cytologic screening" means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women;

(3) "health care provider" means any person authorized within the scope of the person's practice to provide the cancer-related services for which coverage is required pursuant to Subsection A of this section; and

(4) "human papillomavirus screening" means a test approved by the United States food and drug administration for detection of the human papillomavirus."

SECTION 3. A new section of the Public Assistance Act is

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enacted to read:

"[NEW MATERIAL] MEDICAL ASSISTANCE--CANCER PREVENTION AND EARLY DETECTION.--

A. The secretary shall ensure that, at a minimum, a medical assistance plan provides the following coverage to recipients:

(1) not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer; provided that nothing in this paragraph shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate;

(2) cytologic and human papillomavirus screening for determining the presence of precancerous or cancerous conditions and other health problems; provided that the coverage shall make available:

(a) cytologic screening, as determined by the health care provider in accordance with national medical standards, for female recipients who are eighteen years of age or older and for female recipients who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening; and

(b) human papillomavirus screening once

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every three years for female recipients who are thirty years of age and older;

(3) for female recipients who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer;

(4) the human papillomavirus vaccine to female recipients nine to fourteen years of age;

(5) screening for cervical cancer every three years for female recipients twenty-one to sixty-five years of age; and

(6) any other screening for the prevention or detection of cancer in women that the secretary of health recommends.

B. The coverage required pursuant to this section shall not be subject to:

(1) recipient cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

C. By November 1, 2018 and each November 1 thereafter, the secretary shall adopt and promulgate any rules necessary to implement the coverage guidelines for screening for the prevention or detection of cancer in women and girls

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pursuant to the recommendations the secretary of health has issued pursuant to Paragraph (6) of Subsection A of this section.

D. A medical assistance plan shall grant a recipient an expedited hearing to appeal any adverse determination made relating to the coverage provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

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

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

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

E. For the purposes of this section:

(1) "cost-sharing" means a deductible, copayment or coinsurance that a recipient is required to pay in accordance with the terms of a medical assistance plan;

(2) "cytologic screening" means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women;

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1 (3) "health care provider" means any person
2 authorized within the scope of the person's practice to provide
3 the cancer-related services for which coverage is required
4 pursuant to Subsection A of this section; and
5 (4) "human papillomavirus screening" means a
6 test approved by the United States food and drug administration
7 for detection of the human papillomavirus."
8 **SECTION 4.** A new section of Chapter 59A, Article 22 NMSA
9 1978 is enacted to read:
10 "[NEW MATERIAL] CANCER-RELATED COVERAGE.--
11 A. Each individual and group health insurance
12 policy, health care plan and certificate of health insurance
13 delivered or issued for delivery in this state shall provide,
14 at a minimum, the following coverage:
15 (1) screening for cervical cancer every three
16 years for female insureds twenty-one to sixty-five years of
17 age;
18 (2) for female insureds who are at increased
19 risk for breast cancer and at low risk for adverse medication
20 effects, prescription drugs that reduce the risk of cancer; and
21 (3) any other screening for the prevention or
22 detection of cancer in women that the secretary of health
23 recommends.
24 B. The coverage required pursuant to this section
25 shall not be subject to:

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(1) insured cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

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

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

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

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

D. The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-specific health coverage.

E. For the purposes of this section:

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(1) "cost-sharing" means a deductible, copayment or coinsurance that an insured is required to pay in accordance with the terms of a health insurance policy or plan or certificate of insurance; and

(2) "health care provider" means any person authorized within the scope of the person's practice to provide the cancer-related services for which coverage is required pursuant to Subsection A of this section."

SECTION 5. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] CANCER-RELATED COVERAGE.--

A. Each blanket or group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide, at a minimum, the following coverage:

(1) screening for cervical cancer every three years for female insureds twenty-one to sixty-five years of age;

(2) for female insureds who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer; and

(3) any other screening for the prevention or detection of cancer in women that the secretary of health recommends.

B. The coverage required pursuant to this section

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shall not be subject to:

(1) insured cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

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

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

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

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

D. The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-specific health coverage.

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E. For the purposes of this section:

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

(2) "health care provider" means any person authorized within the scope of the person's practice to provide the cancer-related services for which coverage is required pursuant to Subsection A of this section."

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

"[NEW MATERIAL] CANCER-RELATED COVERAGE.--

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall provide, at a minimum, the following coverage:

(1) screening for cervical cancer every three years for female enrollees twenty-one to sixty-five years of age;

(2) for female enrollees who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer; and

(3) any other screening for the prevention or detection of cancer in women that the secretary of health recommends.

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B. The coverage required pursuant to this section shall not be subject to:

(1) enrollee cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

C. A carrier shall grant an enrollee an expedited hearing to appeal any adverse determination made relating to the coverage provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

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

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

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

D. The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-

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specific health coverage.

E. For the purposes of this section:

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

(2) "health care provider" means any person authorized within the scope of the person's practice to provide the cancer-related services for which coverage is required pursuant to Subsection A of this section."

SECTION 7. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] CANCER-RELATED COVERAGE.--

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state shall provide, at a minimum, the following coverage:

(1) low-dose screening mammograms for determining the presence of breast cancer. This coverage shall make available one baseline mammogram to subscribers thirty-five through thirty-nine years of age, one mammogram biennially to subscribers forty through forty-nine years of age and one mammogram annually to subscribers fifty years of age and over. This coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American

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college of radiology accreditation standards for mammography;

(2) not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer; provided that nothing in this paragraph shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate;

(3) cytologic and human papillomavirus screening for determining the presence of precancerous or cancerous conditions and other health problems; provided that the coverage shall make available:

(a) cytologic screening, as determined by the health care provider in accordance with national medical standards, for female subscribers who are eighteen years of age or older and for female subscribers who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening; and

(b) human papillomavirus screening once every three years for female subscribers aged thirty and older;

(4) the human papillomavirus vaccine to female subscribers nine to fourteen years of age;

(5) screening for cervical cancer every three years for female subscribers twenty-one to sixty-five years of

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age;

(6) for female subscribers who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer; and

(7) any other screening for the prevention or detection of cancer in women that the secretary of health recommends.

B. The coverage required pursuant to this section shall not be subject to:

(1) subscriber cost-sharing;

(2) utilization review;

(3) prior authorization or step therapy requirements; or

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

C. A health care plan shall grant a subscriber an expedited hearing to appeal any adverse determination made relating to the coverage provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

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

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

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

D. The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-specific health coverage.

E. For the purposes of this section:

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

(2) "cytologic screening" means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women;

(3) "health care provider" means any person authorized within the scope of the person's practice to provide the cancer-related services for which coverage is required pursuant to Subsection A of this section; and

(4) "human papillomavirus screening" means a test approved by the United States food and drug administration for detection of the human papillomavirus."

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