AN ACT

RELATING TO HEALTH INSURANCE; UPDATING COVERAGE FOR INDIVIDUALS WITH DIABETES; REQUIRING CONSISTENT AND TIMELY DELIVERY OF MEDICALLY NECESSARY DIABETIC RESOURCES.

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

SECTION 1. Section 13-7-25 NMSA 1978 (being Laws 2020, Chapter 36, Section 1) is amended to read:

"13-7-25. COVERAGE FOR INDIVIDUALS WITH DIABETES--INSULIN FOR DIABETES--COST-SHARING CAP.--

A. Group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall cap the amount an insured is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative at an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply and shall provide coverage for individuals with diabetes as required by law for each health care insurer, including:

(1) group health insurance policies, health care plans, certificates of health insurance and managed health care plans delivered or issued for delivery in New Mexico;

(2) group health plans provided through a cooperative;

(3) group health maintenance organization contracts delivered or issued for delivery in New Mexico; and

(4) health benefit plans.

B. As used in this section, "health care insurer" means a person who provides health insurance in this state, including a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a managed care organization, a nonprofit health care organization, a multiple-employer welfare arrangement or any other person providing a plan of health insurance subject to state regulation."

SECTION 2. Section 59A-22-41 NMSA 1978 (being Laws 1997, Chapter 7, Section 1 and Laws 1997, Chapter 255, Section 1, as amended) is amended to read:

"59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Each individual and group health insurance policy, health care plan, certificate of health insurance and managed health care plan delivered or issued for delivery in this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment

as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for individuals with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. An insurer that requires a covered person to use a specific network provider or to purchase equipment,

appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes resources, whether covered under the health policy's prescription drug or medical benefit;

(2) have network contracts in place for the entire policy or plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a covered person in a timely manner and when needed by the covered person;

(4) guarantee reimbursement to a covered person within thirty days following receipt of a written

demand from the covered person who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the covered person, and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a covered person if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from covered persons received by the health care insurer;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care insurer within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care insurer pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care insurer or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care insurer or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health insurers offering policies, plans or certificates as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent

determines that a health care insurer has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care insurer's compliance with this section.

H. Absent a change in diagnosis or in a covered person's management or treatment of diabetes or its complications, a health care insurer shall not require more than one prior authorization per policy period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the covered person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a covered person has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

I. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease policies.

J. For purposes of this section:

(1) "basic health care benefits":

(a) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(b) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment; and

(2) "managed health care plan" means a health benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating health care providers. A managed health care plan includes only those plans that provide comprehensive basic health care services to enrollees on a prepaid, capitated basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations."

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

"COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Each group health insurance contract and blanket health insurance contract delivered or issued for delivery in this state shall provide coverage for individuals with diabetes who use insulin, individuals with diabetes who do not use insulin and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, as long as the annual deductibles or coinsurance for benefits are no

greater than the annual deductibles or coinsurance established for similar benefits within a given policy. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for persons with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances

for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. An insurer that requires a covered person to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes resources whether covered under the health policy's prescription drug or medical benefit;

(2) have network contracts in place for the entire policy or plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a covered person in a timely manner and when needed by the covered person;

(4) guarantee reimbursement to a covered person within thirty days following receipt of a written demand from the covered person who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered in a timely manner to the covered person and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a

covered person if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from covered persons received by the health care insurer;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care insurer within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care insurer pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care insurer or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care insurer or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health insurers offering policies, plans or certificates as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health care insurer has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care insurer's compliance with this section.

H. Absent a change in diagnosis or in a covered person's management or treatment of diabetes or its complications, a health care insurer shall not require more than one prior authorization per policy period for any single

drug or category of item enumerated in this section if prescribed as medically necessary by the covered person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a covered person has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

I. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease policies.

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment."

SECTION 4. Section 59A-46-43 NMSA 1978 (being Laws 1997, Chapter 7, Section 3 and Laws 1997, Chapter 255, Section 3, as amended) is amended to read:

"59A-46-43. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care service and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given contract. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance organization contract shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for individuals with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance contract shall be entitled to the following basic health care services:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the

federal food and drug administration, each individual or group health maintenance organization contract shall:

(1) maintain an adequate formulary to provide these resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. A health maintenance organization that requires an enrollee to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide covered persons with medically necessary diabetes resources whether covered under the health maintenance organization contract's prescription drug or medical benefit;

(2) have network contracts in place for the entire contract period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the

requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to an enrollee in a timely manner and when needed by the enrollee;

(4) guarantee reimbursement to an enrollee within thirty days following receipt of a written demand from the enrollee who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the enrollee and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to an enrollee if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from enrollees

received by the health maintenance organization;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health maintenance organization within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health maintenance organization pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health maintenance organization or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection;

and

(c) the number of complaints received by the health maintenance organization or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health maintenance organizations offering contracts as described in Subsection A of this section for compliance with the requirements of this section. If the superintendent determines that a health maintenance organization has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health maintenance organization's compliance with this section.

H. Absent a change in diagnosis or in an enrollee's management or treatment of diabetes or its complications, a health maintenance organization shall not require more than one prior authorization per policy period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the enrollee's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of

supplies needed to use or operate devices for which an enrollee has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the enrollee's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not a covered benefit.

I. The provisions of this section do not apply to short-term travel, accident-only or limited or specified disease policies.

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment."

SECTION 5. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Each health care plan delivered or issued for delivery in this state shall provide coverage for individuals

with diabetes who use insulin, individuals with diabetes who do not use insulin and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same plan as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given plan. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health care plans described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those

for persons with disabilities, including the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health care plans described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that

shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a diagnosis from a health care practitioner that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal food and drug administration, all health care plans as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide those resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin or supplies described in this subsection within the limits of the health care plan.

F. A health care plan that requires a subscriber to use a specific network provider or to purchase equipment, appliances, supplies or insulin or prescription drugs for the treatment or management of diabetes from a specific durable medical equipment supplier or other supplier as a condition of coverage, payment or reimbursement shall:

(1) maintain an adequate network of durable medical equipment suppliers and other suppliers to provide subscribers with medically necessary diabetes resources whether covered under the health care plan's prescription drug or medical benefit;

(2) have network contracts in place for the entire plan period and shall not allow contracts with network providers, durable medical equipment suppliers and other suppliers to lapse or terminate without ensuring the availability of a replacement and continuity of care; provided that single-case agreements do not satisfy the requirements of Paragraph (1) of this subsection or this paragraph;

(3) monitor network providers, durable medical equipment suppliers and other network suppliers to ensure that medically necessary equipment, appliances, supplies and insulin or other prescription drugs are being delivered to a subscriber in a timely manner and when needed by the subscriber;

(4) guarantee reimbursement to a subscriber within thirty days following receipt of a written demand from the subscriber who pays out of pocket for necessary equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely to the subscriber and the portion of payment for which the patient is responsible shall not exceed the amount for the same covered benefit obtained from a contracted supplier;

(5) pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a subscriber if not paid within thirty days as required by Paragraph (4) of this subsection;

(6) beginning on April 1, 2024, submit a written report each quarter to the superintendent for the previous quarter on the following metrics:

(a) the number of written demands for reimbursement of out-of-pocket expenses from subscribers received by the health care plan;

(b) the number of out-of-pocket claims for reimbursement paid and the aggregate amount of claims reimbursed by the health care plan within the time required by Paragraph (4) of this subsection;

(c) the number of out-of-pocket claims for reimbursement paid more than thirty days following

receipt of a written demand and the aggregate amount of these payments, excluding interest; and

(d) the aggregate amount of interest paid by the health care plan pursuant to Paragraph (5) of this subsection; and

(7) beginning on April 1, 2024, submit a written report each quarter for the previous quarter to the superintendent with the following information for each durable medical equipment supplier or other supplier that was under contract with the health care plan or its agent during the previous quarter:

(a) the name, address and telephone number of each supplier and, if applicable, the corresponding date upon which the respective supplier's contract expired, lapsed or was terminated during the previous quarter;

(b) the percentage of total deliveries, by description of item, that did not meet the delivery requirements specified in Paragraph (3) of this subsection; and

(c) the number of complaints received by the health care plan or its agent during the previous quarter related to late deliveries, incomplete orders or incorrect orders, respectively.

G. The superintendent shall annually audit all health care plans as described in Subsection A of this

section for compliance with the requirements of this section. If the superintendent determines that a health care plan has not complied with the requirements of this section, the superintendent shall impose corrective action or use any other enforcement mechanism available to the superintendent to obtain the health care plan's compliance with this section.

H. Absent a change in diagnosis or in a subscriber's management or treatment of diabetes or its complications, a health care plan shall not require more than one prior authorization per plan period for any single drug or category of item enumerated in this section if prescribed as medically necessary by the subscriber's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a subscriber has received prior authorization during the plan year shall not be subject to additional prior authorization requirements in the same plan year if prescribed as medically necessary by the subscriber's health care practitioner. Nothing in this subsection shall be construed to require payment for diabetes resources that are not covered benefits.

I. The provisions of this section do not apply to:

(1) a short-term health care plan;

(2) an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies;

(3) a policy or plan for long-term care or disability income; or

(4) short-term travel policy or plan.

J. For purposes of this section, "basic health care benefits":

(1) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(2) does not include services for alcohol or drug abuse, dental or long-term rehabilitation treatment."

SECTION 6. TEMPORARY PROVISION--DIABETES COVERAGE WORK GROUP.--

A. By October 1, 2023, the office of superintendent of insurance shall convene a diabetes insurance coverage work group composed of:

(1) a representative of the office who shall serve as the chairperson of the working group;

(2) a representative of the New Mexico

health insurance exchange who is not an employee or board member of a health insurance issuer or qualified health plan;

(3) a representative of a qualified health plan that offers a health benefit plan on the New Mexico health insurance exchange;

(4) a representative of a diabetes advisory council that represents individuals and groups across New Mexico that are trying to reduce the burden of diabetes on individuals, families, communities, the health care system and the state;

(5) a representative of a New Mexico podiatric and medical association with expertise in the treatment and management of diabetes and its complications;

(6) a representative of a New Mexico medical society with expertise in the treatment and management of diabetes and its complications;

(7) a physician specializing in the treatment and management of diabetes and its complications who is affiliated with a New Mexico medical school;

(8) a representative of the university of New Mexico health sciences center with expertise in the treatment and management of diabetes and its complications;

(9) a representative of a New Mexico advanced practice nurses' association with expertise in the treatment and management of diabetes and its complications;

(10) a person diagnosed with type 1 diabetes or family member of a person diagnosed with type 1 diabetes;

(11) a person diagnosed with type 2 diabetes or family member of a person diagnosed with type 2 diabetes;

(12) an advocate for populations disproportionately impacted by diabetes; and

(13) a representative of the risk management division of the general services department with expertise in health care insurance and finance.

B. By August 1, 2024, the work group shall report to the interim legislative health and human services committee regarding its findings and recommendations for expanding and updating New Mexico's essential health benefit benchmark plan to better address the needs of New Mexicans for services, equipment, supplies, appliances and drugs to treat and manage diabetes and its complications.

SECTION 7. APPLICABILITY.--The provisions of this act apply to self-insurance provided pursuant to the Health Care Purchasing Act, individual and group health insurance policies, health care plans, certificates of health insurance, managed health care plans, contracts of health insurance, group health plans provided through a cooperative, individual and group health maintenance organization contracts, health benefit plans and group health coverage that are offered, delivered or issued for delivery, renewed, extended or amended

in New Mexico on or after January 1, 2024.