

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 53

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

AN ACT

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

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

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1 total of twenty-five dollars (\$25.00) per thirty-day supply and
2 shall provide coverage for individuals with diabetes as
3 required by law for each health care insurer, including:

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

7 (2) group health plans provided through a
8 cooperative;

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

11 (4) health benefit plans.

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

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

23 "59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

24 A. Each individual and group health insurance
25 policy, health care plan, certificate of health insurance and

1 managed health care plan delivered or issued for delivery in
2 this state shall provide coverage for individuals with insulin-
3 using diabetes, with non-insulin-using diabetes and with
4 elevated blood glucose levels induced by pregnancy. This
5 coverage shall be a basic health care benefit and shall entitle
6 each individual to the medically accepted standard of medical
7 care for diabetes and benefits for diabetes treatment as well
8 as diabetes supplies, and this coverage shall not be reduced or
9 eliminated.

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

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

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1 treat diabetes:

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

4 (2) test strips for blood glucose monitors;

5 (3) visual reading urine and ketone strips;

6 (4) lancets and lancet devices;

7 (5) insulin;

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

11 (7) syringes;

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

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

20 (10) glucagon emergency kits.

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

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

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

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

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

14 (2) medical nutrition therapy related to
15 diabetes management.

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

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

24 (2) guarantee reimbursement or coverage for
25 the equipment, appliances, prescription drug, insulin or

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1 supplies described in this subsection within the limits of the
2 health care plan, policy or certificate.

3 ~~[F. The provisions of Subsections A through E of~~
4 ~~this section shall be enforced by the superintendent.~~

5 ~~G. The provisions of this section shall not apply~~
6 ~~to short-term travel, accident-only or limited or specified~~
7 ~~disease policies.]~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (c) the number of complaints received by

1 the health care insurer or its agent during the previous
2 quarter related to late deliveries, incomplete orders or
3 incorrect orders, respectively.

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

13 H. Absent a change in diagnosis or in a covered
14 person's management or treatment of diabetes or its
15 complications, a health care insurer shall not require more
16 than one prior authorization per policy period for any single
17 drug or category of item enumerated in this section if
18 prescribed as medically necessary by the covered person's
19 health care practitioner. Changes in the prescribed dose of a
20 drug; quantities of supplies needed to administer a prescribed
21 drug; quantities of blood glucose self-testing equipment and
22 supplies; or quantities of supplies needed to use or operate
23 devices for which a covered person has received prior
24 authorization during the policy year shall not be subject to
25 additional prior authorization requirements in the same policy

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1 year if prescribed as medically necessary by the covered
2 person's health care practitioner. Nothing in this subsection
3 shall be construed to require payment for diabetes resources
4 that are not covered benefits.

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

8 [H.] J. For purposes of this section:

9 (1) "basic health care benefits":

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

15 (b) does not include [~~mental health~~
16 ~~services or~~] services for alcohol or drug abuse, dental [~~or~~
17 ~~vision services~~] or long-term rehabilitation treatment; and

18 (2) "managed health care plan" means a health
19 benefit plan offered by a health care insurer that provides for
20 the delivery of comprehensive basic health care services and
21 medically necessary services to individuals enrolled in the
22 plan through its own employed health care providers or by
23 contracting with selected or participating health care
24 providers. A managed health care plan includes only those
25 plans that provide comprehensive basic health care services to

1 enrollees on a prepaid, capitated basis, including the
2 following:

- 3 (a) health maintenance organizations;
- 4 (b) preferred provider organizations;
- 5 (c) individual practice associations;
- 6 (d) competitive medical plans;
- 7 (e) exclusive provider organizations;
- 8 (f) integrated delivery systems;
- 9 (g) independent physician-provider
10 organizations;
- 11 (h) physician hospital-provider
12 organizations; and
- 13 (i) managed care services
14 organizations."

15 SECTION 3. A new section of Chapter 59A, Article 23 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] COVERAGE FOR INDIVIDUALS WITH DIABETES.--

18 A. Each group health insurance contract and blanket
19 health insurance contract delivered or issued for delivery in
20 this state shall provide coverage for individuals with diabetes
21 who use insulin, individuals with diabetes who do not use
22 insulin and with elevated blood glucose levels induced by
23 pregnancy. This coverage shall be a basic health care benefit
24 and shall entitle each individual to the medically accepted
25 standard of medical care for diabetes and benefits for diabetes

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

3 B. Except as otherwise provided in this subsection,
4 coverage for individuals with diabetes may be subject to
5 deductibles and coinsurance consistent with those imposed on
6 other benefits under the same policy, as long as the annual
7 deductibles or coinsurance for benefits are no greater than the
8 annual deductibles or coinsurance established for similar
9 benefits within a given policy. The amount an individual with
10 diabetes is required to pay for a preferred formulary
11 prescription insulin drug or a medically necessary alternative
12 is an amount not to exceed a total of twenty-five dollars
13 (\$25.00) per thirty-day supply.

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

- 20 (1) blood glucose monitors, including those
21 for persons with disabilities, including the legally blind;
22 (2) test strips for blood glucose monitors;
23 (3) visual reading urine and ketone strips;
24 (4) lancets and lancet devices;
25 (5) insulin;

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

4 (7) syringes;

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

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

13 (10) glucagon emergency kits.

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

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

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

25 (b) visits following a diagnosis from a

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1 health care practitioner that represents a significant change
2 in the patient's symptoms or condition that warrants changes in
3 the patient's self-management; and

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

7 (2) medical nutrition therapy related to
8 diabetes management.

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

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

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

21 F. An insurer that requires a covered person to use
22 a specific network provider or to purchase equipment,
23 appliances, supplies or insulin or prescription drugs for the
24 treatment or management of diabetes from a specific durable
25 medical equipment supplier or other supplier as a condition of

1 coverage, payment or reimbursement shall:

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

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

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

20 (4) guarantee reimbursement to a covered
21 person within thirty days following receipt of a written demand
22 from the covered person who pays out of pocket for necessary
23 equipment, appliances, supplies and insulin or other
24 prescription drugs described in this section that are not
25 delivered in a timely manner to the covered person and the

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1 portion of payment for which the patient is responsible shall
2 not exceed the amount for the same covered benefit obtained
3 from a contracted supplier;

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

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

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

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

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

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

25 (7) beginning on April 1, 2024, submit a

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1 written report each quarter for the previous quarter to the
2 superintendent with the following information for each durable
3 medical equipment supplier or other supplier that was under
4 contract with the health care insurer or its agent during the
5 previous quarter:

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

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

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

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

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

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

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

23 (1) means benefits for medically necessary
24 services consisting of preventive care, emergency care,
25 inpatient and outpatient hospital and physician care,

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1 diagnostic laboratory and diagnostic and therapeutic
2 radiological services; and

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

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

8 "59A-46-43. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

19 B. Except as provided in this subsection, coverage
20 for individuals with diabetes may be subject to deductibles and
21 coinsurance consistent with those imposed on other benefits
22 under the same contract, as long as the annual deductibles or
23 coinsurance for benefits are no greater than the annual
24 deductibles or coinsurance established for similar benefits
25 within a given contract. The amount an individual with

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1 diabetes is required to pay for a preferred formulary
2 prescription insulin drug or a medically necessary alternative
3 is an amount not to exceed a total of twenty-five dollars
4 (\$25.00) per thirty-day supply.

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

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

13 (2) test strips for blood glucose monitors;

14 (3) visual reading urine and ketone strips;

15 (4) lancets and lancet devices;

16 (5) insulin;

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

20 (7) syringes;

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

23 (9) medically necessary podiatric appliances
24 for prevention of feet complications associated with diabetes,
25 including therapeutic molded or depth-inlay shoes, functional

1 orthotics, custom molded inserts, replacement inserts,
2 preventive devices and shoe modifications for prevention and
3 treatment; and

4 (10) glucagon emergency kits.

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

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

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

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

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

23 (2) medical nutrition therapy related to
24 diabetes management.

25 E. When new or improved equipment, appliances,

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1 prescription drugs for the treatment of diabetes, insulin or
2 supplies for the treatment of diabetes are approved by the
3 federal food and drug administration, each individual or group
4 health maintenance organization contract shall:

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

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

11 ~~[F. The provisions of Subsections A through E of~~
12 ~~this section shall be enforced by the superintendent.~~

13 ~~G. The provisions of this section shall not apply~~
14 ~~to short-term travel, accident-only or limited or specified~~
15 ~~disease policies.]~~

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

22 (1) maintain an adequate network of durable
23 medical equipment suppliers and other suppliers to provide
24 covered persons with medically necessary diabetes resources
25 whether covered under the health maintenance organization

1 contract's prescription drug or medical benefit;

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

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

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

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

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

4 (a) the number of written demands for
5 reimbursement of out-of-pocket expenses from enrollees received
6 by the health maintenance organization;

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

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

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

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

24 (a) the name, address and telephone
25 number of each supplier and, if applicable, the corresponding

1 date upon which the respective supplier's contract expired,
2 lapsed or was terminated during the previous quarter;

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

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

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

20 H. Absent a change in diagnosis or in an enrollee's
21 management or treatment of diabetes or its complications, a
22 health maintenance organization shall not require more than one
23 prior authorization per policy period for any single drug or
24 category of item enumerated in this section if prescribed as
25 medically necessary by the enrollee's health care practitioner.

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1 Changes in the prescribed dose of a drug; quantities of
2 supplies needed to administer a prescribed drug; quantities of
3 blood glucose self-testing equipment and supplies; or
4 quantities of supplies needed to use or operate devices for
5 which an enrollee has received prior authorization during the
6 policy year shall not be subject to additional prior
7 authorization requirements in the same policy year if
8 prescribed as medically necessary by the enrollee's health care
9 practitioner. Nothing in this subsection shall be construed to
10 require payment for diabetes resources that are not a covered
11 benefit.

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

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

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

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

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

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1 "[NEW MATERIAL] COVERAGE FOR INDIVIDUALS WITH DIABETES.--

2 A. Each health care plan delivered or issued for
3 delivery in this state shall provide coverage for individuals
4 with diabetes who use insulin, individuals with diabetes who do
5 not use insulin and with elevated blood glucose levels induced
6 by pregnancy. This coverage shall be a basic health care
7 benefit and shall entitle each individual to the medically
8 accepted standard of medical care for diabetes and benefits for
9 diabetes treatment as well as diabetes supplies, and this
10 coverage shall not be reduced or eliminated.

11 B. Except as otherwise provided in this subsection,
12 coverage for individuals with diabetes may be subject to
13 deductibles and coinsurance consistent with those imposed on
14 other benefits under the same plan as long as the annual
15 deductibles or coinsurance for benefits are no greater than the
16 annual deductibles or coinsurance established for similar
17 benefits within a given plan. The amount an individual with
18 diabetes is required to pay for a preferred formulary
19 prescription insulin drug or a medically necessary alternative
20 is an amount not to exceed a total of twenty-five dollars
21 (\$25.00) per thirty-day supply.

22 C. When prescribed or diagnosed by a health care
23 practitioner with prescribing authority, all individuals with
24 diabetes as described in Subsection A of this section enrolled
25 in health care plans described in that subsection shall be

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1 entitled to the following equipment, supplies and appliances to
2 treat diabetes:

- 3 (1) blood glucose monitors, including those
- 4 for persons with disabilities, including the legally blind;
- 5 (2) test strips for blood glucose monitors;
- 6 (3) visual reading urine and ketone strips;
- 7 (4) lancets and lancet devices;
- 8 (5) insulin;
- 9 (6) injection aids, including those adaptable
- 10 to meet the needs of persons with disabilities, including the
- 11 legally blind;
- 12 (7) syringes;
- 13 (8) prescriptive oral agents for controlling
- 14 blood sugar levels;
- 15 (9) medically necessary podiatric appliances
- 16 for prevention of feet complications associated with diabetes,
- 17 including therapeutic molded or depth-inlay shoes, functional
- 18 orthotics, custom molded inserts, replacement inserts,
- 19 preventive devices and shoe modifications for prevention and
- 20 treatment; and
- 21 (10) glucagon emergency kits.

22 D. When prescribed or diagnosed by a health care
23 practitioner with prescribing authority, all individuals with
24 diabetes as described in Subsection A of this section enrolled
25 in health care plans described in that subsection shall be

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1 entitled to the following basic health care benefits:

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

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

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

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

15 (2) medical nutrition therapy related to
16 diabetes management.

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

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

24 (2) guarantee reimbursement or coverage for
25 the equipment, appliances, prescription drugs, insulin or

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1 supplies described in this subsection within the limits of the
2 health care plan.

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

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

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

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

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

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

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

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

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

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

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1 excluding interest; and

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

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

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

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

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

22 G. The superintendent shall annually audit all
23 health care plans as described in Subsection A of this section
24 for compliance with the requirements of this section. If the
25 superintendent determines that a health care plan has not

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1 complied with the requirements of this section, the
2 superintendent shall impose corrective action or use any other
3 enforcement mechanism available to the superintendent to obtain
4 the health care plan's compliance with this section.

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

22 I. The provisions of this section do not apply to:
23 (1) a short-term health care plan;
24 (2) an excepted benefit health care plan
25 intended to supplement major medical coverage, including

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1 medicare supplement, vision, dental, disease-specific,
2 accident-only or hospital indemnity-only insurance policies;

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

5 (4) short-term travel policy or plan.

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

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

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

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

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

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

22 (2) a representative of the New Mexico health
23 insurance exchange who is not an employee or board member of a
24 health insurance issuer or qualified health plan;

25 (3) a representative of a qualified health

1 plan that offers a health benefit plan on the New Mexico health
2 insurance exchange;

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

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

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

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

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

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

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

25 (11) a person diagnosed with type 2 diabetes

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1 or family member of a person diagnosed with type 2 diabetes;

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

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

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

14 SECTION 7. APPROPRIATION.--Three hundred fifty thousand
15 dollars (\$350,000) is appropriated from the general fund to the
16 office of superintendent of insurance for expenditure in fiscal
17 year 2024 to hire additional personnel to conduct or contract
18 for annual compliance audits of health care insurers and
19 enforce compliance with this 2023 act. Any unexpended or
20 unencumbered balance remaining at the end of fiscal year 2024
21 shall revert to the general fund.

22 SECTION 8. APPLICABILITY.--The provisions of this act
23 apply to self-insurance provided pursuant to the Health Care
24 Purchasing Act, individual and group health insurance policies,
25 health care plans, certificates of health insurance, managed

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1 health care plans, contracts of health insurance, group health
2 plans provided through a cooperative, individual and group
3 health maintenance organization contracts, health benefit plans
4 and group health coverage that are offered, delivered or issued
5 for delivery, renewed, extended or amended in New Mexico on or
6 after January 1, 2024.

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