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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;

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

3 (4) health benefit plans.

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

13 SECTION 2. Section 59A-22-41 NMSA 1978 (being Laws
14 1997, Chapter 7, Section 1 and Laws 1997, Chapter 255,
15 Section 1, as amended) is amended to read:

16 "59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

17 A. Each individual and group health insurance
18 policy, health care plan, certificate of health insurance and
19 managed health care plan delivered or issued for delivery in
20 this state shall provide coverage for individuals with
21 insulin-using diabetes, with non-insulin-using diabetes and
22 with elevated blood glucose levels induced by pregnancy.

23 This coverage shall be a basic health care benefit and shall
24 entitle each individual to the medically accepted standard of
25 medical care for diabetes and benefits for diabetes treatment

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

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

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

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

24 (2) test strips for blood glucose monitors;

25 (3) visual reading urine and ketone strips;

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

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

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

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

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

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

10 (2) medical nutrition therapy related to
11 diabetes management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 J. For purposes of this section:

2 (1) "basic health care benefits":

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

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

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

21 (a) health maintenance organizations;

22 (b) preferred provider organizations;

23 (c) individual practice associations;

24 (d) competitive medical plans;

25 (e) exclusive provider organizations;

1 (f) integrated delivery systems;
2 (g) independent physician-provider
3 organizations;
4 (h) physician hospital-provider
5 organizations; and
6 (i) managed care services
7 organizations."

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

10 "COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

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

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

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

15 (2) test strips for blood glucose monitors;

16 (3) visual reading urine and ketone strips;

17 (4) lancets and lancet devices;

18 (5) insulin;

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

22 (7) syringes;

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

25 (9) medically necessary podiatric appliances

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

6 (10) glucagon emergency kits.

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

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

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

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

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

1 (2) medical nutrition therapy related to
2 diabetes management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 SECTION 4. Section 59A-46-43 NMSA 1978 (being Laws
2 1997, Chapter 7, Section 3 and Laws 1997, Chapter 255,
3 Section 3, as amended) is amended to read:

4 "59A-46-43. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

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

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

10 (2) test strips for blood glucose monitors;

11 (3) visual reading urine and ketone strips;

12 (4) lancets and lancet devices;

13 (5) insulin;

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

17 (7) syringes;

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

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

1 (10) glucagon emergency kits.

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

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

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

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

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

21 (2) medical nutrition therapy related to
22 diabetes management.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 received by the health maintenance organization;

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

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

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

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

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

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

1 and

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

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

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

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

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

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

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

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

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

23 "COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

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

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

25 (1) blood glucose monitors, including those

1 for persons with disabilities, including the legally blind;

2 (2) test strips for blood glucose monitors;

3 (3) visual reading urine and ketone strips;

4 (4) lancets and lancet devices;

5 (5) insulin;

6 (6) injection aids, including those

7 adaptable to meet the needs of persons with disabilities,

8 including the legally blind;

9 (7) syringes;

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

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

18 (10) glucagon emergency kits.

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

25 (1) diabetes self-management training that

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

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

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

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

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

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

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

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

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

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

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

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

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
4 equipment, appliances, supplies and insulin or other
5 prescription drugs described in this section that are not
6 delivered timely to the subscriber and the portion of payment
7 for which the patient is responsible shall not exceed the
8 amount for the same covered benefit obtained from a
9 contracted supplier;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 I. The provisions of this section do not apply to: HHC/HB 53/a
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- 1 (1) a short-term health care plan;
- 2 (2) an excepted benefit health care plan
- 3 intended to supplement major medical coverage, including
- 4 medicare supplement, vision, dental, disease-specific,
- 5 accident-only or hospital indemnity-only insurance policies;
- 6 (3) a policy or plan for long-term care or
- 7 disability income; or
- 8 (4) short-term travel policy or plan.

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

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

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

18 **SECTION 6. TEMPORARY PROVISION--DIABETES COVERAGE WORK**
19 **GROUP.--**

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

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

25 (2) a representative of the New Mexico

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

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

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

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

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

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

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

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

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

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

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

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

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

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

