

1 AN ACT
2 RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO
3 INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND
4 THE NONPROFIT HEALTH CARE PLAN LAW TO REQUIRE COVERAGE FOR
5 CERTAIN DURABLE MEDICAL EQUIPMENT FOR THE TREATMENT OF ACTIVE
6 DIABETIC FOOT ULCERS.

7
8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

9 SECTION 1. Section 59A-22-41 NMSA 1978 (being Laws
10 1997, Chapter 7, Section 1 and Laws 1997, Chapter 255,
11 Section 1, as amended) is amended to read:

12 "59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

19 This coverage shall be a basic health care benefit and shall
20 entitle each individual to the medically accepted standard of
21 medical care for diabetes and benefits for diabetes treatment
22 as well as diabetes supplies, and this coverage shall not be
23 reduced or eliminated.

24 B. Except as otherwise provided in this
25 subsection, coverage for individuals with diabetes may be

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

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

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

20 (2) test strips for blood glucose monitors;

21 (3) visual reading urine and ketone strips;

22 (4) lancets and lancet devices;

23 (5) insulin;

24 (6) injection aids, including those

25 adaptable to meet the needs of individuals with disabilities,

1 including the legally blind;

2 (7) syringes;

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

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

11 (10) glucagon emergency kits.

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

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

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

24 (b) visits following a diagnosis from a
25 health care practitioner that represents a significant change

1 in the patient's symptoms or condition that warrants changes
2 in the patient's self-management; and

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

6 (2) medical nutrition therapy related to
7 diabetes management; and

8 (3) medically necessary treatment of active
9 diabetic foot ulcers, including topical oxygen therapy.

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

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

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

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

1 medical equipment supplier or other supplier as a condition
2 of coverage, payment or reimbursement shall:

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

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

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

22 (4) guarantee reimbursement to a covered
23 person within thirty days following receipt of a written
24 demand from the covered person who pays out of pocket for
25 necessary equipment, appliances, supplies and insulin or

1 other prescription drugs described in this section that are
2 not delivered timely to the covered person, and the portion
3 of payment for which the patient is responsible shall not
4 exceed the amount for the same covered benefit obtained from
5 a contracted supplier;

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

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

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

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

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

24 (d) the aggregate amount of interest
25 paid by the health care insurer pursuant to Paragraph (5) of

1 this subsection; and

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

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

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

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

20 G. The superintendent shall annually audit all
21 health insurers offering policies, plans or certificates as
22 described in Subsection A of this section for compliance with
23 the requirements of this section. If the superintendent
24 determines that a health care insurer has not complied with
25 the requirements of this section, the superintendent shall

1 impose corrective action or use any other enforcement
2 mechanism available to the superintendent to obtain the
3 health care insurer's compliance with this section.

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

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

24 J. For purposes of this section:

25 (1) "basic health care benefits":

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

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

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

- 19 (a) health maintenance organizations;
- 20 (b) preferred provider organizations;
- 21 (c) individual practice associations;
- 22 (d) competitive medical plans;
- 23 (e) exclusive provider organizations;
- 24 (f) integrated delivery systems;
- 25 (g) independent physician-provider

1 organizations;

2 (h) physician hospital-provider
3 organizations; and

4 (i) managed care services
5 organizations."

6 SECTION 2. Section 59A-23-7.17 NMSA 1978 (being Laws
7 2023, Chapter 50, Section 3) is amended to read:

8 "59A-23-7.17. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

1 amount an individual with diabetes is required to pay for a
2 preferred formulary prescription insulin drug or a medically
3 necessary alternative is an amount not to exceed a total of
4 twenty-five dollars (\$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
8 enrolled in health policies described in that subsection
9 shall be entitled to the following equipment, supplies and
10 appliances to treat diabetes:

11 (1) blood glucose monitors, including those
12 for persons 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
18 adaptable to meet the needs of persons with disabilities,
19 including 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
25 diabetes, including therapeutic molded or depth-inlay shoes,

1 functional orthotics, custom molded inserts, replacement
2 inserts, preventive devices and shoe modifications for
3 prevention and 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
8 enrolled in health policies described in that subsection
9 shall be entitled to the following basic health care
10 benefits:

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

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

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

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

24 (2) medical nutrition therapy related to
25 diabetes management; and

1 (3) medically necessary treatment of active
2 diabetic foot ulcers, including topical oxygen therapy.

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 3. 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
15 patient is responsible shall not exceed the amount for the
16 same 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 4.** Section 59A-47-45.8 NMSA 1978 (being Laws
22 2023, Chapter 50, Section 5) is amended to read:

23 "59A-47-45.8. 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;

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

15 (3) medically necessary treatment of active
16 diabetic foot ulcers, including topical oxygen therapy.

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
21 as described in Subsection A of this section shall:

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

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

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

3 F. A health care plan that requires a subscriber
4 to 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
8 of 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
12 whether covered under the health care plan's prescription
13 drug or 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;
19 provided that single-case agreements do not satisfy the
20 requirements of Paragraph (1) of this subsection or this
21 paragraph;

22 (3) monitor network providers, durable
23 medical equipment suppliers and other network suppliers to
24 ensure that medically necessary equipment, appliances,
25 supplies and insulin or other prescription drugs are being

1 delivered to a subscriber in a timely manner and when needed
2 by the subscriber;

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

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

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

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

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

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

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

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

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

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

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

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

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

1 are not covered benefits.

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

3 (1) a short-term health care plan;

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

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

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

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

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

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

20 SECTION 5. EFFECTIVE DATE.--The effective date of the
21 provisions of this act is January 1, 2026. _____

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