

HOUSE BILL 53

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

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; UPDATING COVERAGE FOR PERSONS
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 PERSONS 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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underscored material = new
[bracketed material] = delete

1 total of twenty-five dollars (\$25.00) per thirty-day supply and
2 shall provide coverage for persons with diabetes as required by
3 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] PERSONS WITH
24 DIABETES.--

25 A. For purposes of this section:

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1 (1) "basic health care benefit" means a
2 benefit meeting the medically accepted standard of care for
3 diabetes for medically necessary:

4 (a) services consisting of preventive
5 care, emergency care, inpatient and outpatient hospital and
6 medical care, diagnostic laboratory services and diagnostic and
7 therapeutic radiological services;

8 (b) equipment, appliances, devices,
9 diabetes technology and supplies for the management or
10 treatment of diabetes; and

11 (c) insulin, insulin analogs and other
12 prescription drugs for the management or treatment of diabetes;

13 (2) "covered person" means a person with
14 diabetes who is entitled to receive health care benefits
15 provided by an individual or group health insurance policy,
16 health care plan, certificate of health insurance or managed
17 health care plan delivered or issued for delivery in New
18 Mexico;

19 (3) "device" means an instrument, apparatus,
20 implement, machine, contrivance, implant, in-vitro reagent or
21 other similar or related article, including any component, part
22 or accessory, that is:

23 (a) recognized in an official
24 compendium;

25 (b) intended for use in the diagnosis of

1 diabetes or in the management or treatment of diabetes; and

2 (c) intended to affect the structure or
3 a function of the human body and that does not achieve any of
4 its principal intended purposes through chemical action within
5 or on the human body and that is not dependent on being
6 metabolized for achievement of any of its principal intended
7 purposes;

8 (4) "diabetes technology" means devices,
9 hardware and software approved by the federal food and drug
10 administration for use by a covered person to manage or treat
11 that person's diabetes;

12 (5) "drug" means an article that:

13 (a) is recognized in an official
14 compendium;

15 (b) affects the structure or function of
16 the human body and that is approved by the federal food and
17 drug administration, including components and biologic
18 medications;

19 (c) is intended for use in the
20 diagnosis, management or treatment of diabetes; and

21 (d) is not a device or the component
22 part or accessory of a device;

23 (6) "health care insurer" means a person who
24 provides health insurance in New Mexico, including a licensed
25 insurance company, a licensed fraternal benefit society, a

1 prepaid hospital or medical service plan, a health maintenance
2 organization, a nonprofit health care organization, a managed
3 health care plan, a multiple-employer welfare arrangement or
4 any other person who provides a plan of health insurance
5 subject to state insurance regulation;

6 (7) "health care practitioner" means a person
7 licensed by the state to provide health care services who has
8 prescriptive authority and who is acting within the scope of
9 the person's license;

10 (8) "managed health care plan" means a health
11 benefit plan offered by a health care insurer that provides for
12 the delivery of comprehensive basic health care services and
13 medically necessary services to covered persons enrolled in the
14 plan through the health care insurer's own employed health care
15 practitioners or by contracting with selected or participating
16 health care practitioners or suppliers. A "managed health care
17 plan" includes only those plans that provide comprehensive
18 basic health care services to covered persons on a prepaid
19 capitated basis, including:

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

1 (g) independent physician-provider
2 organizations;

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

5 (i) managed care services organizations;

6 (9) "medically accepted standard of care for
7 diabetes" means the clinical practice recommendations of a
8 national diabetes association that is designated by the federal
9 centers for medicare and medicaid services as an accrediting
10 organization for diabetes self-management training, as
11 published annually or supplemented and in effect as of the
12 inception or renewal of the covered person's health insurance
13 policy, plan or contract;

14 (10) "official compendium" means the official
15 United States pharmacopeia and national formulary of the United
16 States or supplements to either of them; and

17 (11) "prior authorization" means advance
18 approval that is required by a health insurance policy, plan or
19 contract as a condition precedent to payment for medical care
20 or related benefits rendered to a covered person, including
21 prospective or utilization review conducted prior to the
22 provision of medical care or related benefits.

23 ~~[A.]~~ B. Each individual and group health insurance
24 policy, health care plan, certificate of health insurance and
25 managed health care plan delivered or issued for delivery in

1 this state shall provide coverage for ~~[individuals with~~
2 ~~insulin-using diabetes, with non-insulin-using diabetes and~~
3 ~~with elevated blood glucose levels induced by pregnancy]~~
4 persons with type 1 diabetes, type 2 diabetes or gestational
5 diabetes. This coverage shall meet the medically accepted
6 standard of care for diabetes and 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-] C. Except as otherwise provided in this
12 ~~[subsection, coverage for individuals with diabetes may be~~
13 ~~subject to deductibles and coinsurance consistent with those~~
14 ~~imposed on other benefits under the same policy, plan or~~
15 ~~certificate, as long as the annual deductibles or coinsurance~~
16 ~~for benefits are no greater than the annual deductibles or~~
17 ~~coinsurance established for similar benefits within a given~~
18 ~~policy]~~ section, the coverage required by this section for
19 covered persons shall be the same as that for other benefits
20 covered by the same policy, plan or certificate with respect
21 to:

22 (1) deductibles, coinsurance, other patient
23 cost-sharing amounts or out-of-pocket limits; and

24 (2) prior authorization or other utilization
25 review requirements or processes.

1 D. The amount ~~[an individual with diabetes]~~ a
2 covered person is required to pay for a preferred formulary
3 prescription insulin drug or a medically necessary alternative
4 is an amount not to exceed a total of twenty-five dollars
5 (\$25.00) per thirty-day supply.

6 ~~[G.]~~ E. When prescribed ~~[or diagnosed]~~ by a health
7 care practitioner ~~[with prescribing authority, all individuals~~
8 ~~with diabetes as described in Subsection A of this section~~
9 ~~enrolled in health policies described in that subsection shall~~
10 ~~be]~~ in accordance with the medically accepted standard of care
11 for diabetes as medically necessary, all covered persons are
12 entitled to the following commercially available equipment,
13 ~~[supplies and]~~ appliances, devices, diabetes technology, drugs
14 and supplies to treat diabetes or its complications:

15 ~~[(1) blood glucose monitors, including those~~
16 ~~for the legally blind;~~

17 ~~(2) test strips for blood glucose monitors;~~

18 ~~(3) visual reading urine and ketone strips;~~

19 ~~(4) lancets and lancet devices;~~

20 ~~(5) insulin;~~

21 ~~(6) injection aids, including those adaptable~~
22 ~~to meet the needs of the legally blind;~~

23 ~~(7) syringes;~~

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

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

7 ~~(10) glucagon emergency kits]~~

8 (1) blood glucose monitors and continuous
9 blood glucose monitors, including those designed for use with
10 adaptive devices and for persons with disabilities, including
11 persons with visual impairment or neuropathy, and includes
12 equipment necessary for the monitor's function, such as
13 transmitters and sensors;

14 (2) test strips for glucose monitors, glucose
15 control solutions, lancet devices and lancets approved by the
16 federal food and drug administration for monitoring glycemic
17 control;

18 (3) visual reading and urine test strips for
19 glucose or ketones or both; provided that urine test strips for
20 only glucose are not acceptable as the sole method of
21 monitoring;

22 (4) insulin or insulin analog preparations
23 available in either vials or cartridges;

24 (5) injection aids and devices to assist with
25 insulin injection, including those adaptable to meet the needs

1 of persons with disabilities, including persons with visual
2 impairment or neuropathy;

3 (6) needles, syringes, pen-like insulin
4 injection devices and pen needles for pen-like insulin
5 injection devices;

6 (7) insulin pumps and alternate controller-
7 enabled infusion pumps; skin preparations, adhesive supplies,
8 infusion sets, cartridges, batteries and other disposable
9 supplies needed to maintain insulin pump therapy; and durable
10 and disposable devices used to assist in the injection of
11 insulin;

12 (8) diabetes technology, automated insulin
13 delivery systems, sensor-augmented insulin pumps and other
14 digital health technologies;

15 (9) prescription drugs for controlling blood
16 sugar levels;

17 (10) podiatric appliances for prevention of
18 complications associated with diabetes, including therapeutic
19 molded or depth-inlay shoes, replacement inserts, other shoe
20 modifications and preventive devices; and

21 (11) glucagon emergency kits and injectable
22 glucagon.

23 F. Nothing in Subsection E of this section shall be
24 construed to limit coverage for new or improved equipment,
25 appliances, devices, diabetes technology, supplies, insulin or

1 other prescription drugs for the management or treatment of
2 diabetes when such resources are approved by the federal food
3 and drug administration and become commercially available.

4 ~~[D.]~~ G. When prescribed ~~[or diagnosed]~~ by a health
5 care practitioner, ~~[with prescribing authority, all individuals~~
6 ~~with diabetes as described in Subsection A of this section~~
7 ~~enrolled in health policies described in that subsection shall~~
8 ~~be]~~ covered persons are entitled to the following as part of
9 basic health care benefits:

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

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

16 (b) visits following a ~~[physician]~~
17 diagnosis that represents a significant change in the patient's
18 symptoms or condition that warrants changes in the patient's
19 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,~~

1 ~~prescription drugs for the treatment of diabetes, insulin or~~
2 ~~supplies for the treatment of diabetes are approved by the food~~
3 ~~and drug administration, all individual or group health~~
4 ~~insurance policies as described in Subsection A of this~~
5 ~~section]~~ H. Every health care insurer shall:

6 (1) maintain an adequate formulary to provide
7 ~~[these]~~ medically necessary diabetes resources to ~~[individuals~~
8 ~~with diabetes; and~~

9 ~~(2) guarantee reimbursement or coverage for~~
10 ~~the equipment, appliances, prescription drug, insulin or~~
11 ~~supplies described in this subsection within the limits of the~~
12 ~~health care plan, policy or certificate]~~ covered persons;

13 (2) maintain an adequate network of durable
14 medical equipment suppliers and other suppliers of the basic
15 health care benefits enumerated in Subparagraphs (b) and (c) of
16 Paragraph (1) of Subsection A of this section to provide
17 covered persons with medically necessary diabetes resources
18 whether covered under the health policy's prescription drug or
19 medical benefit;

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

1 not satisfy the requirements of Paragraph (2) of this
2 subsection or this paragraph;

3 (4) monitor network providers, durable medical
4 equipment suppliers and other network suppliers to ensure that
5 medically necessary equipment, appliances, devices, diabetes
6 technology, supplies and insulin or other prescription drugs
7 are being delivered to a covered person in a timely manner and
8 at least thirty days before needed by the covered person;

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

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

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

25 (a) the number of written demands for

1 reimbursement of out-of-pocket expenses from covered persons
2 received by the health care insurer;

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

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

11 (d) the aggregate amount of interest
12 paid by the health care insurer pursuant to Paragraph (6) of
13 this subsection; and

14 (8) beginning on April 1, 2024, submit a
15 written report each quarter for the previous quarter to the
16 superintendent with the following information for each durable
17 medical equipment supplier or other supplier of the basic
18 health care benefits enumerated in Subparagraphs (b) and (c) of
19 Paragraph (1) of Subsection A of this section and who were
20 under contract with the health care insurer or its agent during
21 the previous quarter:

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

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

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

8 [F.] I. The provisions of [~~Subsections A through E~~
9 ~~of~~] this section shall be enforced by the superintendent. If
10 the superintendent determines that a health care insurer has
11 not contracted with a sufficient number of providers or
12 suppliers as required by this section, the superintendent shall
13 impose corrective action or use any other enforcement mechanism
14 available to the superintendent to obtain the health care
15 insurer's compliance with this section.

16 J. Absent a change in diagnosis or in a covered
17 person's management or treatment of diabetes, a health care
18 insurer shall not require more than one prior authorization per
19 policy period for any single drug, device or category of item
20 enumerated in Paragraphs (1) through (11) of Subsection E of
21 this section if prescribed as medically necessary by the
22 covered person'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 self-
25 testing equipment and supplies; or quantities of supplies

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

8 [G.] K. The provisions of this section [shall] do
9 not apply to short-term travel, accident-only or limited or
10 specified disease policies.

11 [H. ~~For purposes of this section:~~

12 (1) ~~"basic health care benefits":~~

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

18 (b) ~~does not include mental health~~
19 ~~services or services for alcohol or drug abuse, dental or~~
20 ~~vision services or long-term rehabilitation treatment; and~~

21 (2) ~~"managed health care plan" means a health~~
22 ~~benefit plan offered by a health care insurer that provides for~~
23 ~~the delivery of comprehensive basic health care services and~~
24 ~~medically necessary services to individuals enrolled in the~~
25 ~~plan through its own employed health care providers or by~~

1 ~~contracting with selected or participating health care~~
2 ~~providers. A managed health care plan includes only those~~
3 ~~plans that provide comprehensive basic health care services to~~
4 ~~enrollees on a prepaid, capitated basis, including the~~
5 ~~following:~~

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

18 SECTION 3. Section 59A-23-11 NMSA 1978 (being Laws 2011,
19 Chapter 34, Section 2) is amended to read:

20 "59A-23-11. PRIVATE HEALTH INSURANCE COOPERATIVES--
21 INCORPORATION--COVERAGE FOR PERSONS WITH DIABETES.--

22 A. A person may form a cooperative to purchase
23 employer health benefit plans. A cooperative shall be
24 organized as a nonprofit corporation and has the rights and
25 duties provided by the Nonprofit Corporation Act.

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1 B. Two or more large employers or small employers
2 or any combination of large employers and small employers with
3 an aggregate of fifty or more full-time-equivalent employees
4 may purchase group health benefit plans pursuant to ~~[Chapter~~
5 ~~59A, Article 23 NMSA 1978]~~ this article.

6 C. A carrier shall not form, or be a member of, a
7 cooperative. A carrier may associate with a sponsoring entity,
8 such as a business association, chamber of commerce or other
9 organization representing employers or serving an analogous
10 function, to assist the sponsoring entity in forming a
11 cooperative.

12 D. A cooperative shall:

13 (1) arrange for group health benefit plan
14 coverage for employer groups that participate in the
15 cooperative by contracting with carriers pursuant to Chapter
16 59A, Article 23 NMSA 1978;

17 (2) collect premiums to cover the cost of:

18 (a) group health benefit plan coverage
19 purchased through the cooperative; and

20 (b) the cooperative's administrative
21 expenses;

22 (3) establish administrative and accounting
23 procedures for the operation of the cooperative;

24 (4) establish procedures under which an
25 applicant for or participant in group health benefit plan

1 coverage issued through the cooperative may have a grievance
2 reviewed by an impartial person;

3 (5) contract with carriers to provide services
4 to employers covered through the cooperative; and

5 (6) develop and implement a plan to maintain
6 public awareness of the cooperative and publicize the
7 eligibility requirements for, and the procedures for enrollment
8 in, group health benefit plan coverage through the cooperative.

9 E. A cooperative may negotiate the premiums paid by
10 its members.

11 F. Notwithstanding the provisions of Subsections B
12 and C of this section, a cooperative may restrict membership to
13 employers within a single industry grouping as defined by the
14 most recent edition of the United States census bureau's *North*
15 *American Industry Classification System*.

16 G. A carrier shall issue health benefit plan
17 coverage for the cooperative through a licensed agent marketing
18 the coverage in accordance with the provisions of [~~Chapter 59A,~~
19 ~~Article 23 NMSA 1978~~] this article.

20 H. The members of a cooperative shall be considered
21 a single risk pool.

22 I. A cooperative may make available to its members
23 more than one group health benefit plan, but each plan shall be
24 made available to all employees covered by the cooperative.

25 J. The provisions of this section do not limit or

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1 restrict a small or large employer's access to health benefit
2 plans pursuant to the Insurance Code.

3 K. A group health benefit plan provided through a
4 cooperative shall provide diabetes coverage [~~for diabetes~~
5 ~~equipment, supplies and services~~] as required by law for all
6 group health insurance policies, health care plans,
7 certificates of health insurance and managed health care plans
8 delivered or issued for delivery in New Mexico.

9 L. A carrier may elect not to participate in a
10 cooperative. The carrier may elect to participate in one or
11 more cooperatives and may select the cooperatives in which the
12 carrier will participate.

13 M. A cooperative shall not self-insure or self-fund
14 any health benefit plan or portion of a plan.

15 N. A cooperative may contract only with a carrier
16 that demonstrates that the carrier:

17 (1) is in good standing with the division;

18 (2) has the capacity to administer health
19 benefit plans;

20 (3) is able to monitor and evaluate the
21 quality and cost-effectiveness of care and applicable
22 procedures;

23 (4) is able to conduct utilization management
24 and establish applicable procedures and policies;

25 (5) is able to ensure that enrollees have

1 adequate access to health care [~~providers~~] practitioners,
2 including adequate numbers and types of [~~providers~~]
3 practitioners;

4 (6) has a satisfactory grievance procedure and
5 is able to respond to enrollees' calls, questions and
6 complaints; and

7 (7) has financial capacity, either through
8 satisfying financial solvency standards that the superintendent
9 shall set or through appropriate reinsurance or other risk-
10 sharing mechanisms.

11 O. A cooperative is not a carrier or an insurer,
12 and an employee of the cooperative shall not be required to be
13 licensed as an agent or broker pursuant to the provisions of
14 the Insurance Code. This exemption from licensure includes a
15 cooperative that acts to provide information about and to
16 solicit membership in the cooperative.

17 P. A cooperative shall register as a cooperative
18 with the insurance division in accordance with division rules.

19 Q. For the purposes of this section:

20 (1) "carrier" means a person that is subject
21 to licensure by the superintendent or subject to the provisions
22 of the Insurance Code and that provides one or more health
23 benefit or insurance plans in the state;

24 (2) "large employer" means a person, firm,
25 corporation, partnership or association actively engaged in

1 business that, on at least fifty percent of its working days
2 during either of the two preceding years, employed no fewer
3 than fifty-one employees eligible for employer-sponsored
4 coverage; provided that:

5 (a) in determining the number of
6 eligible employees, the spouse or dependent of an employee may,
7 at the employer's discretion, be counted as a separate
8 employee;

9 (b) companies that are affiliated
10 companies or that are eligible to file a combined tax return
11 for purposes of state income taxation shall be considered one
12 employer;

13 (c) in the case of an employer that was
14 not in existence throughout a preceding calendar year, the
15 determination of whether the employer is a small or large
16 employer shall be based on the average number of employees that
17 it is reasonably expected to employ on working days in the
18 current calendar year; and

19 (d) the employer does not self-insure;
20 and

21 (3) "small employer" means a person, firm,
22 corporation, partnership or association actively engaged in
23 business that, on at least fifty percent of its working days
24 during either of the two preceding years, employed no less than
25 two and no more than fifty employees eligible for employer-

1 sponsored coverage; provided that:

2 (a) in determining the number of
3 eligible employees, the spouse or dependent of an employee may,
4 at the employer's discretion, be counted as a separate
5 employee;

6 (b) companies that are affiliated
7 companies or that are eligible to file a combined tax return
8 for purposes of state income taxation shall be considered one
9 employer;

10 (c) in the case of an employer that was
11 not in existence throughout a preceding calendar year, the
12 determination of whether the employer is a small or large
13 employer shall be based on the average number of employees that
14 it is reasonably expected to employ on working days in the
15 current calendar year; and

16 (d) the employer does not self-insure."

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

20 "59A-46-43. COVERAGE FOR ~~[INDIVIDUALS]~~ PERSONS WITH
21 DIABETES.--

22 A. For purposes of this section:

23 (1) "basic health care benefit" means a
24 benefit meeting the medically accepted standard of care for
25 diabetes for medically necessary:

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1 (a) services consisting of preventive
2 care, emergency care, inpatient and outpatient hospital and
3 medical care, diagnostic laboratory services and diagnostic and
4 therapeutic radiological services;

5 (b) equipment, appliances, devices,
6 diabetes technology and supplies for the management or
7 treatment of diabetes; and

8 (c) insulin, insulin analogs and other
9 prescription drugs for the management or treatment of diabetes;

10 (2) "covered person" means a person with
11 diabetes who is entitled to receive health care benefits
12 provided by an individual or group health maintenance
13 organization delivered or issued for delivery in New Mexico;

14 (3) "device" means an instrument, apparatus,
15 implement, machine, contrivance, implant, in-vitro reagent or
16 other similar or related article, including any component, part
17 or accessory, that is:

18 (a) recognized in an official
19 compendium;

20 (b) intended for use in the diagnosis of
21 diabetes or in the management or treatment of diabetes; and

22 (c) intended to affect the structure or
23 a function of the human body and that does not achieve any of
24 its principal intended purposes through chemical action within
25 or on the human body and that is not dependent on being

1 metabolized for achievement of any of its principal intended
2 purposes;

3 (4) "diabetes technology" means devices,
4 hardware and software approved by the federal food and drug
5 administration for use by a covered person to manage or treat
6 that person's diabetes;

7 (5) "drug" means an article that:

8 (a) is recognized in an official
9 compendium;

10 (b) affects the structure or function of
11 the human body and that is approved by the federal food and
12 drug administration, including components and biologic
13 medications;

14 (c) is intended for use in the
15 diagnosis, management or treatment of diabetes; and

16 (d) is not a device or the component
17 part or accessory of a device;

18 (6) "health care practitioner" means a person
19 licensed by the state to provide health care services who has
20 prescriptive authority and who is acting within the scope of
21 the person's license;

22 (7) "medically accepted standard of care for
23 diabetes" means the clinical practice recommendations of a
24 national diabetes association that is designated by the federal
25 centers for medicare and medicaid services as an accrediting

1 organization for diabetes self-management training, as
2 published annually or supplemented and in effect as of the
3 inception or renewal of the covered person's contract;

4 (8) "official compendium" means the official
5 United States pharmacopeia and national formulary of the United
6 States or supplements to either of them; and

7 (9) "prior authorization" means advance
8 approval that is required by a health maintenance organization
9 as a condition precedent to payment for medical care or related
10 benefits rendered to a covered person, including prospective or
11 utilization review conducted prior to the provision of medical
12 care or related benefits.

13 ~~[A.]~~ B. Each individual and group health
14 maintenance organization contract delivered or issued for
15 delivery in this state shall provide coverage for ~~[individuals~~
16 ~~with insulin-using diabetes, with non-insulin-using diabetes~~
17 ~~and with elevated blood glucose levels induced by pregnancy]~~
18 persons with type 1 diabetes, type 2 diabetes or gestational
19 diabetes. This coverage shall meet the medically accepted
20 standard of care for diabetes and be a basic health care
21 ~~[service]~~ benefit and shall entitle each ~~[individual]~~ covered
22 person to the medically accepted standard of medical care for
23 diabetes and benefits for diabetes management and treatment ~~[as~~
24 ~~well as diabetes supplies]~~ and this coverage shall not be
25 reduced or eliminated.

1 ~~[B.]~~ C. Except as provided in this ~~[subsection,~~
2 ~~coverage for individuals with diabetes may be subject to~~
3 ~~deductibles and coinsurance consistent with those imposed on~~
4 ~~other benefits under the same contract, as long as the annual~~
5 ~~deductibles or coinsurance for benefits are no greater than the~~
6 ~~annual deductibles or coinsurance established for similar~~
7 ~~benefits within a given contract]~~ section, the coverage
8 required by this section shall be the same as that for other
9 benefits covered by the same contract with respect to:

10 (1) deductibles, coinsurance, other patient
11 cost-sharing amounts or out-of-pocket limits; and

12 (2) prior authorization or other utilization
13 review requirements or processes.

14 D. The amount ~~[an individual with diabetes]~~ a
15 covered person is required to pay for a preferred formulary
16 prescription insulin drug or a medically necessary alternative
17 is an amount not to exceed a total of twenty-five dollars
18 (\$25.00) per thirty-day supply.

19 ~~[G.]~~ E. When prescribed ~~[or diagnosed]~~ by a health
20 care practitioner ~~[with prescribing authority, all individuals~~
21 ~~with diabetes as described in Subsection A of this section~~
22 ~~enrolled under an individual or group health maintenance~~
23 ~~organization contract]~~ in accordance with the medically
24 accepted standard of care for diabetes as medically necessary,
25 all covered persons shall be entitled to the following

1 commercially available equipment, [supplies and appliances to]
2 appliances, devices, diabetes technology, supplies and insulin
3 or other prescription drugs to manage and treat diabetes:

4 ~~[(1) blood glucose monitors, including those~~
5 ~~for the legally blind;~~

6 ~~(2) test strips for blood glucose monitors;~~

7 ~~(3) visual reading urine and ketone strips;~~

8 ~~(4) lancets and lancet devices;~~

9 ~~(5) insulin;~~

10 ~~(6) injection aids, including those adaptable~~
11 ~~to meet the needs of the 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 (1) blood glucose monitors and continuous
23 blood glucose monitors, including those designed for use with
24 adaptive devices and for persons with disabilities, including
25 persons with visual impairment or neuropathy, and includes

1 equipment necessary for the monitor's function, such as
2 transmitters and sensors;

3 (2) test strips for glucose monitors, glucose
4 control solutions, lancet devices and lancets approved by the
5 federal food and drug administration for monitoring glycemic
6 control;

7 (3) visual reading and urine test strips for
8 glucose or ketones or both; provided that urine test strips for
9 only glucose are not acceptable as the sole method of
10 monitoring;

11 (4) insulin or insulin analog preparations
12 available in either vials or cartridges;

13 (5) injection aids and devices to assist with
14 insulin injection, including those adaptable to meet the needs
15 of persons with disabilities, including persons with visual
16 impairment or neuropathy;

17 (6) needles, syringes, pen-like insulin
18 injection devices and pen needles for pen-like insulin
19 injection devices;

20 (7) insulin pumps and alternate controller-
21 enabled infusion pumps; skin preparations, adhesive supplies,
22 infusion sets, cartridges, batteries and other disposable
23 supplies needed to maintain insulin pump therapy; and durable
24 and disposable devices used to assist in the injection of
25 insulin;

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1 (8) diabetes technology, automated insulin
2 delivery systems, sensor-augmented insulin pumps and other
3 digital health technologies;

4 (9) prescription drugs for controlling blood
5 sugar levels;

6 (10) podiatric appliances for prevention of
7 complications associated with diabetes, including therapeutic
8 molded or depth-inlay shoes, replacement inserts, other shoe
9 modifications and preventive devices; and

10 (11) glucagon emergency kits and injectable
11 glucagon.

12 F. Nothing in Subsection E of this section shall be
13 construed to limit coverage for new or improved equipment,
14 appliances, devices, diabetes technology, supplies, insulin or
15 other prescription drugs for the management or treatment of
16 diabetes when such resources are approved by the federal food
17 and drug administration and become commercially available.

18 ~~[D.]~~ G. When prescribed ~~[or diagnosed]~~ by a health
19 care practitioner, ~~[with prescribing authority, all individuals~~
20 ~~with diabetes as described in Subsection A of this section]~~ all
21 covered persons enrolled under an individual or group health
22 maintenance contract shall be entitled to the following ~~[basic~~
23 ~~health care services]~~:

24 (1) diabetes self-management training that
25 ~~[shall be]~~ is provided by a certified, registered or licensed

1 health care professional with recent education in diabetes
2 management ~~[which shall be]~~ and that is limited to:

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

5 (b) visits following a ~~[physician]~~
6 diagnosis that represents a significant change in the patient's
7 symptoms or condition that warrants changes in the patient's
8 self-management; and

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

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

14 ~~[E. When new or improved equipment, appliances,~~
15 ~~prescription drugs for the treatment of diabetes, insulin or~~
16 ~~supplies for the treatment of diabetes are approved by the food~~
17 ~~and drug administration]~~ H. Each individual or group health
18 maintenance organization contract shall:

19 (1) maintain an adequate formulary to provide
20 ~~[these]~~ medically necessary diabetes resources to ~~[individuals~~
21 ~~with diabetes; and~~

22 ~~(2) guarantee reimbursement or coverage for~~
23 ~~the equipment, appliances, prescription drug, insulin or~~
24 ~~supplies described in this subsection within the limits of the~~
25 ~~health care plan, policy or certificate]~~ covered persons;

1 (2) maintain an adequate network of durable
2 medical equipment suppliers and other suppliers of the basic
3 health care benefits enumerated in Subparagraphs (b) and (c) of
4 Paragraph (1) of Subsection A of this section to provide
5 covered persons with medically necessary diabetes resources
6 whether covered under the contract's prescription drug or
7 medical benefit;

8 (3) have network contracts in place for the
9 entire individual or group health maintenance organization
10 contract period and shall not allow contracts with network or
11 participating providers, durable medical equipment suppliers
12 and other suppliers or pharmacy benefit managers to lapse or
13 terminate without ensuring the availability of a replacement
14 and continuity of care; provided that single-case agreements do
15 not satisfy the requirements of Paragraph (2) of this
16 subsection or this paragraph;

17 (4) monitor network providers, durable medical
18 equipment suppliers and other network suppliers to ensure that
19 medically necessary equipment, appliances, devices, diabetes
20 technology, supplies and insulin or other prescription drugs
21 are being delivered to a covered person in a timely manner and
22 at least thirty days before needed by the covered person;

23 (5) guarantee reimbursement to a covered
24 person within thirty days following receipt of a written demand
25 from the covered person who pays out of pocket for medically

1 necessary items listed in Paragraph (4) of this subsection that
2 are not delivered timely to the covered person as required by
3 that paragraph, and the portion of payment for which the
4 patient is responsible shall not exceed the amount for the same
5 covered benefit obtained from a contracted supplier;

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

10 (7) 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 maintenance organization;

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

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

24 (d) the aggregate amount of interest
25 paid by the health maintenance organization pursuant to

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1 Paragraph (6) of this subsection; and

2 (8) 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 durable
5 medical equipment supplier or other supplier of the basic
6 health care benefits enumerated in Subparagraphs (b) and (c) of
7 Paragraph (1) of Subsection A of this section and who were
8 under contract with the health maintenance organization or its
9 agent 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 supplier's contract expired, lapsed or was
13 terminated during the previous quarter;

14 (b) the percentage of total deliveries,
15 by description of item, that did not meet the delivery time
16 specified in Paragraph (4) of this subsection; and

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

21 ~~[F.]~~ I. ~~The provisions [of Subsections A through E]~~
22 of this section shall be enforced by the superintendent. If
23 the superintendent determines that a health maintenance
24 organization has not contracted with a sufficient number of
25 health care practitioners or suppliers as required by this

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

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

23 [6.] K. The provisions of this section shall not
24 apply to short-term travel, accident-only or limited or
25 specified disease policies."

1 SECTION 5. APPROPRIATION.--Three hundred fifty thousand
2 dollars (\$350,000) is appropriated from the general fund to the
3 office of superintendent of insurance for expenditure in fiscal
4 year 2024 to hire additional personnel to conduct or contract
5 for random periodic compliance audits of health care insurers
6 and enforce compliance with this act. Any unexpended or
7 unencumbered balance remaining at the end of fiscal year 2024
8 shall revert to the general fund.

9 SECTION 6. APPLICABILITY.--The provisions of this act
10 apply to self-insurance provided pursuant to the Health Care
11 Purchasing Act, individual and group health insurance policies,
12 health care plans, certificates of health insurance, managed
13 health care plans, contracts of health insurance, group health
14 plans provided through a cooperative, individual and group
15 health maintenance organization contracts, health benefit plans
16 and group health coverage that are offered, delivered or issued
17 for delivery, renewed, extended or amended in New Mexico on or
18 after January 1, 2024.