HOUSE BILL 53

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

INTRODUCED BY

Elizabeth "Liz" Thomson

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

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

(2) group health plans provided through a cooperative;

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

(4) health benefit plans.

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

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

"59A-22-41. COVERAGE FOR [~~INDIVIDUALS~~] PERSONS WITH DIABETES.--

A. For purposes of this section:

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

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

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

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

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

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

(a) recognized in an official compendium;

(b) intended for use in the diagnosis of

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diabetes or in the management or treatment of diabetes; and

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

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

(5) "drug" means an article that:

(a) is recognized in an official compendium;

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

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

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

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

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

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

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

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

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(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations;

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

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

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

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

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this state shall provide coverage for [~~individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy~~] persons with type 1 diabetes, type 2 diabetes or gestational diabetes. This coverage shall meet the medically accepted standard of care for diabetes and be a basic health care benefit and [~~shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies and this coverage~~] shall not be reduced or eliminated.

[~~B.~~] C. Except as otherwise provided in this [~~subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy~~] section, the coverage required by this section for covered persons shall be the same as that for other benefits covered by the same policy, plan or certificate with respect to:

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

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

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

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

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

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

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

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

~~(5) insulin;~~

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

~~(7) syringes;~~

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

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

~~(10) glucagon emergency kits~~]

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

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

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

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

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

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

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

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

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

(9) prescription drugs for controlling blood sugar levels;

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

(11) glucagon emergency kits and injectable glucagon.

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

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

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

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

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

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

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

(2) medical nutrition therapy related to diabetes management.

[~~E. When new or improved equipment, appliances,~~

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

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

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

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

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

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

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

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

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

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

(a) the number of written demands for

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a) health maintenance organizations;~~

~~(b) preferred provider organizations;~~

~~(c) individual practice associations;~~

~~(d) competitive medical plans;~~

~~(e) exclusive provider organizations;~~

~~(f) integrated delivery systems;~~

~~(g) independent physician-provider organizations;~~

~~(h) physician hospital-provider organizations; and~~

~~(i) managed care services organizations.~~]"

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

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

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

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

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

D. A cooperative shall:

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

(2) collect premiums to cover the cost of:

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

(b) the cooperative's administrative expenses;

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

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

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

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

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

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

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

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

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

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

J. The provisions of this section do not limit or

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

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

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

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

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

(1) is in good standing with the division;

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

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

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

(5) is able to ensure that enrollees have

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

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

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

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

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

Q. For the purposes of this section:

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

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

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

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

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

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

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

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

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sponsored coverage; provided that:

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

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

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

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

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

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

A. For purposes of this section:

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

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

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

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

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

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

(a) recognized in an official compendium;

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

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

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metabolized for achievement of any of its principal intended purposes;

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

(5) "drug" means an article that:

(a) is recognized in an official compendium;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(5) insulin;~~

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

~~(7) syringes;~~

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

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

~~(10) glucagon emergency kits~~]

(1) blood glucose monitors and continuous blood glucose monitors, including those designed for use with adaptive devices and for persons with disabilities, including persons with visual impairment or neuropathy, and includes

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

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

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

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

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

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

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

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

(9) prescription drugs for controlling blood sugar levels;

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

(11) glucagon emergency kits and injectable glucagon.

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

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

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

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

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

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

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

(2) medical nutrition therapy related to diabetes management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Paragraph (6) of this subsection; and

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

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

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

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

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

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

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

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

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

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

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