

1 HOUSE BILL 233

2 **57TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2025**

3 INTRODUCED BY

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5 and Eleanor Chávez and Kathleen Cates
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10 AN ACT

11 RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO
12 INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE
13 NONPROFIT HEALTH CARE PLAN LAW TO REQUIRE COVERAGE FOR CERTAIN
14 DURABLE MEDICAL EQUIPMENT FOR THE TREATMENT OF ACTIVE DIABETIC
15 FOOT ULCERS.
16

17 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

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

21 "59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

22 A. Each individual and group health insurance
23 policy, health care plan, certificate of health insurance and
24 managed health care plan delivered or issued for delivery in
25 this state shall provide coverage for individuals with insulin-

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

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

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

- 25 (1) blood glucose monitors, including those

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1 for individuals with disabilities, including the legally blind;

2 (2) test strips for blood glucose monitors;

3 (3) visual reading urine and ketone strips;

4 (4) lancets and lancet devices;

5 (5) insulin;

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

9 (7) syringes;

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

12 (9) medically necessary:

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

18 (b) durable medical equipment for the
19 treatment of active diabetic foot ulcers, including topical
20 oxygen therapy; and

21 (10) glucagon emergency kits.

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

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1 entitled to the following basic health care benefits:

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

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

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

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

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

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

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

25 (2) guarantee reimbursement or coverage for

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1 the equipment, appliances, prescription drug, insulin or
2 supplies described in this subsection within the limits of the
3 health care plan, policy or certificate.

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

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

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

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

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1 person in a timely manner and when needed by the covered
2 person;

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

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

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

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

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

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

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

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

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

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

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

25 G. The superintendent shall annually audit all

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

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

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1 I. The provisions of this section do not apply to
2 short-term travel, accident-only or limited or specified
3 disease policies.

4 J. For purposes of this section:

5 (1) "basic health care benefits":

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

11 (b) does not include services for
12 alcohol or drug abuse, dental or long-term rehabilitation
13 treatment; and

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

- 24 (a) health maintenance organizations;
- 25 (b) preferred provider organizations;

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- 1 (c) individual practice associations;
- 2 (d) competitive medical plans;
- 3 (e) exclusive provider organizations;
- 4 (f) integrated delivery systems;
- 5 (g) independent physician-provider
- 6 organizations;
- 7 (h) physician hospital-provider
- 8 organizations; and
- 9 (i) managed care services
- 10 organizations."

11 SECTION 2. Section 59A-23-7.17 NMSA 1978 (being Laws
12 2023, Chapter 50, Section 3) is amended to read:

13 "59A-23-7.17. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

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

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

- 16 (1) blood glucose monitors, including those
17 for persons with disabilities, including the legally blind;
- 18 (2) test strips for blood glucose monitors;
- 19 (3) visual reading urine and ketone strips;
- 20 (4) lancets and lancet devices;
- 21 (5) insulin;
- 22 (6) injection aids, including those adaptable
23 to meet the needs of persons with disabilities, including the
24 legally blind;
- 25 (7) syringes;

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

3 (9) medically necessary:

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

9 (b) durable medical equipment for the
10 treatment of active diabetic foot ulcers, including topical
11 oxygen therapy; and

12 (10) glucagon emergency kits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 not exceed the amount for the same covered benefit obtained
2 from a contracted supplier;

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

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

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

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

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

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

24 (7) beginning on April 1, 2024, submit a
25 written report each quarter for the previous quarter to the

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

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

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

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

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

25 H. Absent a change in diagnosis or in a covered

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

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

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

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

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1 radiological services; and

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

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

7 "59A-46-43. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

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

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

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

12 (2) test strips for blood glucose monitors;

13 (3) visual reading urine and ketone strips;

14 (4) lancets and lancet devices;

15 (5) insulin;

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

19 (7) syringes;

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

22 (9) medically necessary:

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

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

3 (b) durable medical equipment for the
4 treatment of active diabetic foot ulcers, including topical
5 oxygen therapy; and

6 (10) glucagon emergency kits.

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

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

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

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

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

25 (2) medical nutrition therapy related to

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1 diabetes management.

2 E. When new or improved equipment, appliances,
3 prescription drugs for the treatment of diabetes, insulin or
4 supplies for the treatment of diabetes are approved by the
5 federal food and drug administration, each individual or group
6 health maintenance organization contract shall:

7 (1) maintain an adequate formulary to provide
8 these resources to individuals 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.

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

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

24 (2) have network contracts in place for the
25 entire contract period and shall not allow contracts with

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1 network providers, durable medical equipment suppliers and
2 other suppliers to lapse or terminate without ensuring the
3 availability of a replacement and continuity of care; provided
4 that single-case agreements do not satisfy the requirements of
5 Paragraph (1) of this subsection or this paragraph;

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

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

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

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

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1 (a) the number of written demands for
2 reimbursement of out-of-pocket expenses from enrollees received
3 by the health maintenance organization;

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

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

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

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

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

25 (b) the percentage of total deliveries,

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1 by description of item, that did not meet the delivery
2 requirements specified in Paragraph (3) of this subsection; and

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

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

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

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

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

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

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

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

21 SECTION 4. Section 59A-47-45.8 NMSA 1978 (being Laws
22 2023, Chapter 50, Section 5) is amended to read:

23 "59A-47-45.8. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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

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

8 B. Except as otherwise provided in this subsection,
9 coverage for individuals with diabetes may be subject to
10 deductibles and coinsurance consistent with those imposed on
11 other benefits under the same plan as long as the annual
12 deductibles or coinsurance for benefits are no greater than the
13 annual deductibles or coinsurance established for similar
14 benefits within a given plan. The amount an individual with
15 diabetes 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 C. When prescribed or diagnosed by a health care
20 practitioner with prescribing authority, all individuals with
21 diabetes as described in Subsection A of this section enrolled
22 in health care plans described in that subsection shall be
23 entitled to the following equipment, supplies and appliances to
24 treat diabetes:

- 25 (1) blood glucose monitors, including those

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

22 D. When prescribed or diagnosed by a health care

23 practitioner with prescribing authority, all individuals with

24 diabetes as described in Subsection A of this section enrolled

25 in health care plans described in that subsection shall be

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1 entitled to the following basic health care benefits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 excluding interest; and

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

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

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

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

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

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

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

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

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

- 23 (1) a short-term health care plan;
24 (2) an excepted benefit health care plan
25 intended to supplement major medical coverage, including

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

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

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

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

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

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

15 SECTION 5. APPLICABILITY.--The provisions of this act
16 apply to self-insurance provided pursuant to the Health Care
17 Purchasing Act, individual and group health insurance policies,
18 health care plans, certificates of health insurance, managed
19 health care plans, contracts of health insurance, group health
20 plans provided through a cooperative, individual and group
21 health maintenance organization contracts, health benefit plans
22 and group health coverage that are offered, delivered or issued
23 for delivery, renewed, extended or amended in New Mexico on or
24 after January 1, 2026.