

STATE OF NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE



SUPERINTENDENT OF INSURANCE
Alice T. Kane

DEPUTY SUPERINTENDENT
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BULLETIN 2024-014

July 30, 2024

TO: ALL HEALTH CARE INSURERS LICENSED IN NEW MEXICO PROVIDING 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 BENEFITS PLANS AND GROUP HEALTH COVERAGE THAT ARE OFFERED, DELIVERED, OR ISSUED FOR DELIVERY, RENEWED, EXTENDED, OR AMENDED IN NEW MEXICO IN THE INDIVIDUAL AND SMALL GROUP MARKETS ON OR AFTER JANUARY 1, 2024

RE: HOUSE BILL 53, IMPLEMENTATION – SUBMISSION OF HEALTH INSURANCE POLICIES FOR COMPLIANCE REVIEW

House Bill 53, Delivery of Necessary Diabetic Resources, (HB53) was enacted in the 2023 New Mexico legislative session and became effective on January 1, 2024. HB53 amended certain sections of, and added other sections to, the New Mexico Insurance Code included in Chapter 59A, Articles 22 (Insurance Contracts), 23 (Group and Blanket Health Insurance Contracts), 46 (Health Maintenance Organization Law), and 47 (Nonprofit Health Care Plan Law). The Office of Superintendent of Insurance (OSI), through its Life and Health Division, will enforce the provisions of HB53.

Through its compliance review required by HB53, OSI will review claims processing, provider reimbursement procedures, network adequacy, provider reimbursement rate adequacy, utilization management, level of care determinations and medication coverage to ensure access to resources for diabetics.

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Pursuant to NMSA 1978, Sections 59A-18-12(A) and 59A-18-13, all health insurance or health care plans must be approved by the Superintendent. “Health insurance,” and “Health care plan” are defined in Subsection E of NMSA 1978, Section 59A-18 12. Because each health care plan must notify insureds of their rights as established by HB53, the Superintendent will not approve any health care plan affected by HB53, unless the following language is included in the health care plan:

Coverage for Individuals with Diabetes

Your health benefits plan contract provides coverage for basic health services for individuals with Type 1 diabetes (insulin dependent diabetes), Type 2 diabetes (non-insulin dependent diabetes), and gestational diabetes (individuals with elevated blood glucose levels induced by pregnancy). These basic health services consist of:

- Preventive care
- Emergency care
- Inpatient and outpatient hospital and physician care
- Diagnostic laboratory services
- Diagnostic and therapeutic radiological services
- Prescription medications
- Treatment and supplies

This coverage is a basic health care service that entitles you to the medically accepted standard of medical care for diabetes, when medically necessary, and will not be reduced or eliminated.

Generally, your provider will diagnose you with diabetes and prescribe medically necessary Durable Medical Equipment (DME), diabetic testing supplies, insulin, or other prescription medications used for the treatment of diabetes. Generally, once a provider diagnoses you with diabetes, any provider can then prescribe medically necessary durable medical equipment ("DME"), diabetic testing supplies, insulin, or other prescription medications.

This section explains covered benefits and services. Nothing in this section of your plan contract shall be construed to require payment for diabetes resources that are not covered benefits or services.

Basic Health Care Services

Your health benefits plan covers the following benefits for diabetes self-management training provided by a certified, registered or licensed health care professional with recent education in diabetes management:

- Medically necessary visits upon the diagnosis of diabetes;
- Visits following a diagnosis indicating a significant change in your symptoms or condition that warrants changes in your self-management;
- Visits when re-education or refresher training is prescribed by your provider with prescribing authority;
- Telephonic visits with a Certified Diabetes Educator (CDE). Approved diabetes educators may be required to be practitioners/providers who are registered, certified or licensed health care professional with recent education in diabetes management; and
- Medical nutrition therapy related to diabetes management.

Prescription Medications, DME, Insulin and Supplies

Your plan contract covers DME, diabetic testing supplies, insulin or other prescription medications needed to monitor and control your diabetes as follows:

- Insulin pumps when medically necessary, prescribed by a provider;
- Blood glucose monitors, including those for individuals with disabilities;
- Specialized monitors/meters for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Lancets and lancet devices;
- Insulin;
- Injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;
- Syringes;
- Oral diabetic prescription medications for controlling blood sugar levels;
- Glucagon emergency kits; and
- Medically necessary podiatric DME for prevention of foot complications associated with diabetes as follows:
 - o therapeutic molded or depth-inlay shoes;

- o functional orthotics;
- o custom molded inserts;
- o replacement inserts;
- o preventive devices; and
- o shoe modifications for prevention and treatment.

Your health benefits plan requires the use of approved DME brands that are purchased at in-network pharmacy, preferred vendor or preferred durable medical equipment supplier.

This health benefits plan will also cover items not specifically listed as covered when new and improved DME and prescription medications for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. When such items are approved, we will update our formulary and other information to provide adequate access to these resources. Coverage of newly approved prescription medications for the treatment and management may be subject to prior authorization and step therapy requirements.

Prior Authorization

Medically necessary DME, diabetic testing supplies, insulin or other prescription medications used for the treatment of diabetes and covered under your health benefits plan can be subject to prior authorization and step therapy requirements. We will not require your provider to submit more than one prior authorization request per policy year for any single medication or category of covered item, unless there is a change in your diagnosis, management or treatment of diabetes or its complications. The one prior authorization per year limitation applies to changes in the following:

- prescribed dose of a medication;
- quantities of supplies needed to administer a prescribed medication;
- quantities of blood glucose self-testing equipment and supplies; or
- quantities of supplies needed to use or operate devices for which an enrollee has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if deemed medically necessary by the enrollee's health care practitioner.

Cost sharing

The amount you will pay for a preferred formulary prescription insulin, or a medically necessary alternative will not exceed a total of twenty-five dollars (\$25.00) per thirty-day supply.

Coverage of all other diabetes related benefits, treatment and supplies may be subject to cost sharing (deductible, copay and coinsurance) consistent with the cost sharing imposed to other benefits under the same contract. This cost sharing will not exceed the cost sharing established for similar benefits under your health benefits plan.

Network Access

We maintain an adequate network of providers, pharmacies, durable medical equipment suppliers and other suppliers to provide you with adequate and timely access to medically necessary diabetes resources. If a contract lapses or is terminated, we will ensure the availability and continuity of your care through another network provider or a single-case agreement with an out-of-network provider.

Reimbursement

We guarantee coverage for the medically necessary DME, diabetic testing supplies, insulin or other prescription medications, in this section within the limits of your health benefits plan. We will reimburse you if the before mentioned benefits were not accessible in a timely manner and you incurred out of pocket expenses.

If you are unable to access medically necessary DME, diabetic testing supplies, insulin or other prescription medications covered under this health benefits plan in a timely manner, and when needed, you can:


- contact us at [...] and we will assist you with finding an in-network provider or refer you to an out-of-network provider that can deliver the benefit or service in a timely manner; or
- Pay out of pocket and file a claim with us at [...]. We will reimburse you the amount of the covered benefit on the same basis as if the benefit was obtained in-network. Once we receive your written request and receipt for out-of-pocket expenses, we will reimburse you within 30 (thirty) days. If we fail to reimburse you in a timely manner, we will pay an interest rate of 18 % (eighteen percent) per year on the amount due.

If you are not satisfied with our resolution you can file a complaint with the Office of the Superintendent of Insurance at <https://www.osi.state.nm.us/pages/misc/mhcb-complaint> or by calling 1-855-427-5674, option 3.

The specific review criteria used by the OSI when conducting a compliance review required by HB53 will be provided on the OSI website at: <https://www.osi.state.nm.us/>

OSI may issue targeted audits to ensure compliance with the requirements of HB53. All inquiries related to the content of this bulletin should be directed to Viara Ianakieva at Viara.Ianakieva@osi.nm.gov.

ISSUED this 30th day of July 2024.



ALICE T. KANE
Superintendent of Insurance