HOUSE BILL 131

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

INTRODUCED BY

Elizabeth "Liz" Thomson and Kathleen Cates

and Joshua N. Hernandez and John Block and Siah Correa Hemphill

AN ACT

RELATING TO HEALTH CARE COVERAGE; ENACTING NEW SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE NEW MEXICO INSURANCE CODE TO REQUIRE COVERAGE FOR EXPENSES RELATED TO PROSTHETICS AND CUSTOM ORTHOTIC DEVICES; REQUIRING REPORTING.

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

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PROSTHETIC DEVICES--CUSTOM ORTHOTIC DEVICES--MINIMUM COVERAGE.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, shall provide coverage for prosthetics and custom orthotics that is at least equivalent to that coverage currently provided by the federal medicare program and no less

underscored material = new
[bracketed material] = delete

favorable than the terms and conditions that the group health plan offers for medical and surgical benefits.

B. A group health plan shall cover the most appropriate prosthetic or custom orthotic device determined to be medically necessary by the enrollee's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for the comfort or convenience of the enrollee. This coverage shall include all services and supplies necessary for the effective use of a prosthetic or custom orthotic device, including:

(1) formulation of its design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(2) all materials and components necessary to use it;

(3) instructing the enrollee in the use of it; and

(4) the repair and replacement of it.

C. A group heath plan shall cover a prosthetic or custom orthotic device determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for performing physical activities, including running, biking and swimming and to maximize the enrollee's upper limb function. This coverage shall include all services

underscored material = new
[~~bracketed material~~] = delete

and supplies necessary for the effective use of a prosthetic or custom orthotic device, including:

(1) formulation of its design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(2) all materials and components necessary to use it;

(3) instructing the enrollee in the use of it; and

(4) the repair and replacement of it.

D. A group health plan's reimbursement rate for prosthetic and custom orthotic devices shall be at least equivalent to that currently provided by the federal medicare program and no more restrictive than other coverage under the group health plan.

E. Prosthetic and custom orthotic device coverage shall be comparable to coverage for other medical and surgical benefits under the group health plan, including restorative internal devices such as internal prosthetic devices, and shall not be subject to spending limits or lifetime restrictions.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. A group health plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements

underscored material = new
[~~bracketed material~~] = delete

shall not be more restrictive than the cost-sharing requirements applicable to the plan's medical and surgical benefits, including those for internal devices.

G. A group health plan may limit the coverage for, or alter the cost-sharing requirements for, out-of-network coverage of prosthetic and custom orthotic devices; provided that the restrictions and cost-sharing requirements applicable to prosthetic or custom orthotic devices shall not be more restrictive than the restrictions and requirements applicable to the out-of-network coverage for a group health plan's medical and surgical coverage.

H. The requirements of this section shall apply separately with respect to coverage benefits provided under a group health plan on an in-network basis and benefits provided under that group health plan on an out-of-network basis.

I. A group health plan shall not impose any annual or lifetime dollar maximum on coverage for prosthetic or custom orthotic devices, other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the group health plan.

J. If coverage is provided through a managed care plan, an enrollee shall have access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider

underscored material = new
[~~bracketed material~~] = delete

network located in the state.

K. Coverage for prosthetic and custom orthotic devices shall be considered habilitative or rehabilitative benefits for purposes of any state or federal requirement for coverage of essential health benefits, including habilitative and rehabilitative benefits."

SECTION 2. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROSTHETIC DEVICES--CUSTOM ORTHOTIC DEVICES--MINIMUM COVERAGE.--

A. A health plan shall provide coverage for prosthetic and custom orthotic devices that is at least equivalent to that currently provided by the federal medicare program and no less favorable than the terms and conditions that the health plan offers for medical and surgical benefits.

B. A health plan shall cover the most appropriate prosthetic or custom orthotic device determined to be medically necessary by the enrollee's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for the comfort or convenience of the enrollee. This coverage shall include all services and supplies necessary for the effective use of a prosthetic or custom orthotic device, including:

(1) formulation of its design, fabrication,

underscored material = new
[bracketed material] = delete

material and component selection, measurements, fittings and static and dynamic alignments;

(2) all materials and components necessary to use it;

(3) instructing the enrollee in the use of it; and

(4) the repair and replacement of it.

C. A heath plan shall cover a prosthetic or custom orthotic device determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for performing physical activities, including running, biking and swimming and to maximize the enrollee's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic or custom orthotic device, including:

(1) formulation of its design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(2) all materials and components necessary to use it;

(3) instructing the enrollee in the use of it; and

(4) the repair and replacement of it.

D. A health plan's reimbursement rate for prosthetic and custom orthotic devices shall be at least

underscored material = new
[~~bracketed material~~] = delete

equivalent to that currently provided by the federal medicare program and no more restrictive than other coverage under the health plan.

E. Coverage for prosthetic and custom orthotic devices shall be comparable to coverage for other medical and surgical benefits under the health plan, including restorative internal devices such as internal prosthetic devices, and shall not be subject to spending limits or lifetime restrictions.

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. A health plan may impose cost sharing on prosthetic or custom orthotic devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's medical and surgical benefits, including those for internal devices.

G. A health plan may limit the coverage for or alter the cost-sharing requirements for out-of-network coverage of prosthetic and custom orthotic devices; provided that the restrictions and requirements applicable to prosthetic or custom orthotic devices shall not be more restrictive than the restrictions and requirements applicable to the out-of-network coverage for a health plan's medical and surgical coverage.

H. The requirements of this section shall apply separately with respect to coverage benefits provided under a

underscored material = new
[~~bracketed material~~] = delete

health plan on an in-network basis and benefits provided under that health plan on an out-of-network basis.

I. A health plan shall not impose any annual or lifetime dollar maximum on coverage for prosthetic or custom orthotic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the health plan.

J. If coverage is provided through a managed care plan or health maintenance organization, an enrollee shall have access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's or health maintenance organization's provider network, which providers shall be located in the state.

K. As used in this section, "health plan":

(1) means the following types of major medical coverage:

(a) an individual or group health insurance policy, health care plan or certificate of health insurance subject to the provisions of Article 22 or Article 23 of the Insurance Code that is delivered, issued for delivery or renewed in this state;

(b) an individual or group health maintenance organization contract subject to the Health

underscored material = new
[~~bracketed material~~] = delete

Maintenance Organization Law that is delivered, issued for delivery or renewed in this state; and

(c) an individual or group health care plan subject to the provisions of the Nonprofit Health Care Plan Law that is delivered, issued for delivery or renewed in this state; and

(2) does not mean a health insurance or health coverage policy, plan or certificate of coverage that is intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or any other limited-benefit health insurance policy."

SECTION 3. [NEW MATERIAL] REPORTING.--No later than November 1, 2024 and annually thereafter, the superintendent of insurance shall report aggregated data, including the number and cost of claims paid pursuant to Sections 1 and 2 of this 2023 act, to the legislative health and human services committee and the legislative finance committee.

SECTION 4. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2024.

underscored material = new
[~~bracketed material~~] = delete