

HOUSE FLOOR SUBSTITUTE FOR
HOUSE BILL 131

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

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; PROHIBITING UNFAIR TRADE PRACTICE ON THE BASIS OF DISABILITY.

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

.225290.1

underscored material = new
[bracketed material] = delete

1 currently provided by the federal medicare program and no less
2 favorable than the terms and conditions that the group health
3 plan offers for medical and surgical benefits.

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

- 13 (1) formulation of its design, fabrication,
14 material and component selection, measurements, fittings and
15 static and dynamic alignments;
- 16 (2) all materials and components necessary to
17 use it;
- 18 (3) instructing the enrollee in the use of it;
19 and
- 20 (4) the repair and replacement of it.

21 C. A group health plan shall cover a prosthetic or
22 custom orthotic device determined by the enrollee's provider to
23 be the most appropriate model that meets the medical needs of
24 the enrollee for performing physical activities, including
25 running, biking and swimming and to maximize the enrollee's

1 upper limb function. This coverage shall include all services
2 and supplies necessary for the effective use of a prosthetic or
3 custom orthotic device, including:

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

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

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

11 (4) the repair and replacement of it.

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

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

22 F. Prosthetic and custom orthotic device coverage
23 shall not be subject to separate financial requirements that
24 are applicable only with respect to that coverage. A group
25 health plan may impose cost sharing on prosthetic or custom

.225290.1

1 orthotic devices; provided that any cost-sharing requirements
2 shall not be more restrictive than the cost-sharing
3 requirements applicable to the plan's medical and surgical
4 benefits, including those for internal devices.

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

13 H. In the event that medically necessary covered
14 orthotics and prosthetics are not available from an in-network
15 provider, the insurer shall provide processes to refer a member
16 to an out-of-network provider and shall fully reimburse the
17 out-of-network provider at a mutually agreed upon rate less
18 member cost sharing determined on an in-network basis.

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

24 J. If coverage is provided through a managed care
25 plan, an enrollee shall have access to medically necessary

1 clinical care and to prosthetic and custom orthotic devices and
2 technology from not less than two distinct prosthetic and
3 custom orthotic providers in the managed care plan's provider
4 network located in the state.

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

10 L. If coverage for prosthetic or custom orthotic
11 devices is provided, payment shall be made for the replacement
12 of a prosthetic or custom orthotic device or for the
13 replacement of any part of such devices, without regard to
14 continuous use or useful lifetime restrictions, if an ordering
15 health care provider determines that the provision of a
16 replacement device, or a replacement part of such a device, is
17 necessary because of any of the following:

18 (1) a change in the physiological condition of
19 the patient;

20 (2) an irreparable change in the condition of
21 the device or in a part of the device; or

22 (3) the condition of the device, or the part
23 of the device, requires repairs and the cost of such repairs
24 would be more than sixty percent of the cost of a replacement
25 device or of the part being replaced.

.225290.1

1 M. Confirmation from a prescribing health care
2 provider may be required if the prosthetic or custom orthotic
3 device or part being replaced is less than three years old.

4 N. A group health plan subject to the Health Care
5 Purchasing Act shall not discriminate against individuals based
6 on disability, including limb loss, absence or malformation."

7 SECTION 2. A new section of Chapter 59A, Article 16 NMSA
8 1978 is enacted to read:

9 "[NEW MATERIAL] UNFAIR TRADE PRACTICES ON THE BASIS OF
10 DISABILITY PROHIBITED.--

11 A. Any of the following practices with respect to a
12 health benefits plan are defined as unfair and deceptive
13 practices and are prohibited:

14 (1) canceling or changing the premiums,
15 benefits or conditions of a health benefits plan on the basis
16 of an insured's actual or perceived disability;

17 (2) denying a prosthetic or orthotic benefit
18 for an individual with limb loss or absence that would
19 otherwise be covered for a non-disabled person seeking medical
20 or surgical intervention to restore or maintain the ability to
21 perform the same physical activity;

22 (3) failure to apply the most recent version
23 of treatment and fit criteria developed by the professional
24 association with the most relevant clinical specialty when
25 performing a utilization review for a request for coverage of

.225290.1

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

1 prosthetic or orthotic benefits; and

2 (4) failure to apply medical necessity review
 3 standards developed by the professional association with the
 4 most relevant clinical specialty when conducting utilization
 5 management review or processing appeals regarding benefit
 6 denial.

7 B. For purposes of this section, "health benefits
 8 plan" means a policy or agreement entered into, offered or
 9 issued by a health insurance carrier to provide, deliver,
 10 arrange for, pay for or reimburse the costs of health care
 11 services; provided that "health benefits plan" does not include
 12 the following:

- 13 (1) an accident-only policy;
- 14 (2) a credit-only policy;
- 15 (3) a long- or short-term care or disability
 16 income policy;
- 17 (4) a specified disease policy;
- 18 (5) coverage provided pursuant to Title 18 of
 19 the federal Social Security Act, as amended;
- 20 (6) coverage provided pursuant to Title 19 of
 21 the federal Social Security Act and the Public Assistance Act;
- 22 (7) a federal TRICARE policy, including a
 23 federal civilian health and medical program of the uniformed
 24 services supplement;
- 25 (8) a fixed or hospital indemnity policy;

.225290.1

underscored material = new
 [bracketed material] = delete

- 1 (9) a dental-only policy;
- 2 (10) a vision-only policy;
- 3 (11) a workers' compensation policy;
- 4 (12) an automobile medical payment policy; or
- 5 (13) any other policy specified in rules of
- 6 the superintendent."

7 SECTION 3. A new section of Chapter 59A, Article 22 NMSA
8 1978 is enacted to read:

9 "[NEW MATERIAL] MEDICAL NECESSITY AND NONDISCRIMINATION
10 STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.--

11 A. An individual health plan that is delivered,
12 issued for delivery or renewed in this state that offers
13 coverage for prosthetic and custom orthotic devices shall
14 consider these benefits habilitative or rehabilitative benefits
15 for purposes of any state or federal requirement for coverage
16 of essential health benefits.

17 B. When performing a utilization review for a
18 request for coverage of prosthetic or orthotic benefits, an
19 insurer shall apply the most recent version of evidence-based
20 treatment and fit criteria as recognized by relevant clinical
21 specialists or their organizations. Such standards may be
22 named by the superintendent in rule.

23 C. An insurer shall render utilization review
24 determinations in a nondiscriminatory manner and shall not deny
25 coverage for habilitative or rehabilitative benefits, including

.225290.1

1 prosthetics or orthotics, solely on the basis of an insured's
2 actual or perceived disability.

3 D. An insurer shall not deny a prosthetic or
4 orthotic benefit for an individual with limb loss or absence
5 that would otherwise be covered for a non-disabled person
6 seeking medical or surgical intervention to restore or maintain
7 the ability to perform the same physical activity.

8 E. A health benefits plan that is delivered, issued
9 for delivery or renewed in this state that offers coverage for
10 prosthetics and custom orthotic devices shall include language
11 describing an insured's rights pursuant to Subsections C and D
12 of this section in its evidence of coverage and any benefit
13 denial letters.

14 F. Prosthetic and custom orthotic device coverage
15 shall not be subject to separate financial requirements that
16 are applicable only with respect to that coverage. An
17 individual health plan may impose cost sharing on prosthetic or
18 custom orthotic devices; provided that any cost-sharing
19 requirements shall not be more restrictive than the cost-
20 sharing requirements applicable to the plan's coverage for
21 inpatient physician and surgical services.

22 G. A health plan that provides coverage for
23 prosthetic or orthotic services shall ensure access to
24 medically necessary clinical care and to prosthetic and custom
25 orthotic devices and technology from not less than two distinct

.225290.1

1 prosthetic and custom orthotic providers in the managed care
2 plan's provider network located in the state. In the event
3 that medically necessary covered orthotics and prosthetics are
4 not available from an in-network provider, the insurer shall
5 provide processes to refer a member to an out-of-network
6 provider and shall fully reimburse the out-of-network provider
7 at a mutually agreed upon rate less member cost sharing
8 determined on an in-network basis.

9 H. If coverage for prosthetic or custom orthotic
10 devices is provided, payment shall be made for the replacement
11 of a prosthetic or custom orthotic device or for the
12 replacement of any part of such devices, without regard to
13 continuous use or useful lifetime restrictions, if an ordering
14 health care provider determines that the provision of a
15 replacement device, or a replacement part of such a device, is
16 necessary because of any of the following:

17 (1) a change in the physiological condition of
18 the patient;

19 (2) an irreparable change in the condition of
20 the device or in a part of the device; or

21 (3) the condition of the device, or the part
22 of the device, requires repairs and the cost of such repairs
23 would be more than sixty percent of the cost of a replacement
24 device or of the part being replaced.

25 I. Confirmation from a prescribing health care

1 provider may be required if the prosthetic or custom orthotic
2 device or part being replaced is less than three years old.

3 J. The provisions of this section do not apply to
4 excepted benefits plans subject to the Short-Term Health Plan
5 and Excepted Benefit Act."

6 SECTION 4. A new section of Chapter 59A, Article 23 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] MEDICAL NECESSITY AND NONDISCRIMINATION
9 STANDARDS FOR COVERAGE OF PROSTHETICS AND ORTHOTICS.--

10 A. A group health plan that is delivered, issued
11 for delivery or renewed in this state that covers essential
12 health benefits or covers prosthetic and custom orthotic
13 devices shall consider these benefits habilitative or
14 rehabilitative benefits for purposes of state or federal
15 requirements on essential health benefits coverage.

16 B. When performing a utilization review for a
17 request for coverage of prosthetic or orthotic benefits, an
18 insurer shall apply the most recent version of evidence-based
19 treatment and fit criteria as recognized by relevant clinical
20 specialists or their organizations. Such standards may be
21 named by the superintendent in rule.

22 C. An insurer shall render utilization review
23 determinations in a nondiscriminatory manner and shall not deny
24 coverage for habilitative or rehabilitative benefits, including
25 prosthetics or orthotics, solely based on an insured's actual

.225290.1

1 or perceived disability.

2 D. An insurer shall not deny a prosthetic or
3 orthotic benefit for an individual with limb loss or absence
4 that would otherwise be covered for a non-disabled person
5 seeking medical or surgical intervention to restore or maintain
6 the ability to perform the same physical activity.

7 E. A health benefits plan that is delivered, issued
8 for delivery or renewed in this state that offers coverage for
9 prosthetics and custom orthotic devices shall include language
10 describing an insured's rights pursuant to Subsections C and D
11 of this section in its evidence of coverage and any benefit
12 denial letters.

13 F. Prosthetic and custom orthotic device coverage
14 shall not be subject to separate financial requirements that
15 are applicable only with respect to that coverage. A group
16 health plan may impose cost sharing on prosthetic or custom
17 orthotic devices; provided that any cost-sharing requirements
18 shall not be more restrictive than the cost-sharing
19 requirements applicable to the plan's coverage for inpatient
20 physician and surgical services.

21 G. A group health plan that provides coverage for
22 prosthetic or orthotic services shall ensure access to
23 medically necessary clinical care and to prosthetic and custom
24 orthotic devices and technology from not less than two distinct
25 prosthetic and custom orthotic providers in the managed care

.225290.1

1 plan's provider network located in the state. In the event
2 that medically necessary covered orthotics and prosthetics are
3 not available from an in-network provider, the insurer shall
4 provide processes to refer a member to an out-of-network
5 provider and shall fully reimburse the out-of-network provider
6 at a mutually agreed upon rate less member cost sharing
7 determined on an in-network basis.

8 H. If coverage for prosthetic or custom orthotic
9 devices is provided, payment shall be made for the replacement
10 of a prosthetic or custom orthotic device or for the
11 replacement of any part of such devices, without regard to
12 continuous use or useful lifetime restrictions, if an ordering
13 health care provider determines that the provision of a
14 replacement device, or a replacement part of such a device, is
15 necessary because of any of the following:

16 (1) a change in the physiological condition of
17 the patient;

18 (2) an irreparable change in the condition of
19 the device or in a part of the device; or

20 (3) the condition of the device, or the part
21 of the device, requires repairs and the cost of such repairs
22 would be more than sixty percent of the cost of a replacement
23 device or of the part being replaced.

24 I. Confirmation from a prescribing health care
25 provider may be required if the prosthetic or custom orthotic

.225290.1

1 device or part being replaced is less than three years old.

2 J. The provisions of this section do not apply to
3 excepted benefits plans subject to the Short-Term Health Plan
4 and Excepted Benefit Act."

5 SECTION 5. A new section of the Health Maintenance
6 Organization Law is enacted to read:

7 "[NEW MATERIAL] MEDICAL NECESSITY AND NONDISCRIMINATION
8 STANDARDS FOR COVERAGE OF PROSTHETICS AND ORTHOTICS.--

9 A. An individual or group health maintenance
10 organization contract that is delivered, issued for delivery or
11 renewed in this state that covers essential health benefits and
12 covers prosthetic and custom orthotic devices shall consider
13 these benefits habilitative or rehabilitative benefits for
14 purposes of state or federal requirements on essential health
15 benefits coverage.

16 B. When performing a utilization review for a
17 request for coverage of prosthetic or orthotic benefits, an
18 insurer shall apply the most recent version of evidence-based
19 treatment and fit criteria as recognized by relevant clinical
20 specialists or their organizations. Such standards may be
21 named by the superintendent in rule.

22 C. An insurer shall render utilization review
23 determinations in a nondiscriminatory manner and shall not deny
24 coverage for habilitative or rehabilitative benefits, including
25 prosthetics or orthotics, solely based on an insured's actual

.225290.1

1 or perceived disability.

2 D. An insurer shall not deny a prosthetic or
3 orthotic benefit for an individual with limb loss or absence
4 that would otherwise be covered for a non-disabled person
5 seeking medical or surgical intervention to restore or maintain
6 the ability to perform the same physical activity.

7 E. A health benefits plan that is delivered, issued
8 for delivery or renewed in this state that offers coverage for
9 prosthetics and custom orthotic devices shall include language
10 describing an insured's rights pursuant to Subsections C and D
11 of this section in its evidence of coverage and any benefit
12 denial letters.

13 F. Prosthetic and custom orthotic device coverage
14 shall not be subject to separate financial requirements that
15 are applicable only with respect to that coverage. An
16 individual or group health plan may impose cost sharing on
17 prosthetic or custom orthotic devices; provided that any cost-
18 sharing requirements shall not be more restrictive than the
19 cost-sharing requirements applicable to the plan's coverage for
20 inpatient physician and surgical services.

21 G. An individual or group health plan that provides
22 coverage for prosthetic or orthotic services shall ensure
23 access to medically necessary clinical care and to prosthetic
24 and custom orthotic devices and technology from not less than
25 two distinct prosthetic and custom orthotic providers in the

.225290.1

1 managed care plan's provider network located in the state. In
2 the event that medically necessary covered orthotics and
3 prosthetics are not available from an in-network provider, the
4 insurer shall provide processes to refer a member to an out-of-
5 network provider and shall fully reimburse the out-of-network
6 provider at a mutually agreed upon rate less member cost
7 sharing determined on an in-network basis.

8 H. If coverage for prosthetic or custom orthotic
9 devices is provided, payment shall be made for the replacement
10 of a prosthetic or custom orthotic device or for the
11 replacement of any part of such devices, without regard to
12 continuous use or useful lifetime restrictions, if an ordering
13 health care provider determines that the provision of a
14 replacement device, or a replacement part of such a device, is
15 necessary because of any of the following:

16 (1) a change in the physiological condition of
17 the patient;

18 (2) an irreparable change in the condition of
19 the device or in a part of the device; or

20 (3) the condition of the device, or the part
21 of the device, requires repairs and the cost of such repairs
22 would be more than sixty percent of the cost of a replacement
23 device or of the part being replaced.

24 I. Confirmation from a prescribing health care
25 provider may be required if the prosthetic or custom orthotic

1 device or part being replaced is less than three years old.

2 J. The provisions of this section do not apply to
3 excepted benefits plans subject to the Short-Term Health Plan
4 and Excepted Benefit Act."

5 SECTION 6. A new section of the Nonprofit Health Care
6 Plan Law is enacted to read:

7 "[NEW MATERIAL] MEDICAL NECESSITY AND NONDISCRIMINATION
8 STANDARDS FOR COVERAGE OF PROSTHETICS AND ORTHOTICS.--

9 A. An individual or group health care plan that is
10 delivered, issued for delivery or renewed in this state that
11 covers essential health benefits and covers prosthetic and
12 custom orthotic devices shall consider these benefits
13 habilitative or rehabilitative benefits for purposes of state
14 or federal requirements on essential health benefits coverage.

15 B. When performing a utilization review for a
16 request for coverage of prosthetic or orthotic benefits, an
17 insurer shall apply the most recent version of evidence-based
18 treatment and fit criteria as recognized by relevant clinical
19 specialists or their organizations. Such standards may be
20 named by the superintendent in rule.

21 C. An insurer shall render utilization review
22 determinations in a nondiscriminatory manner and shall not deny
23 coverage for habilitative or rehabilitative benefits, including
24 prosthetics or orthotics, solely based on an insured's actual
25 or perceived disability.

.225290.1

1 D. An insurer shall not deny a prosthetic or
2 orthotic benefit for an individual with limb loss or absence
3 that would otherwise be covered for a non-disabled person
4 seeking medical or surgical intervention to restore or maintain
5 the ability to perform the same physical activity.

6 E. A health benefits plan that is delivered, issued
7 for delivery or renewed in this state that offers coverage for
8 prosthetics and custom orthotic devices shall include language
9 describing an insured's rights pursuant to Subsections C and D
10 of this section in its evidence of coverage and any benefit
11 denial letters.

12 F. Prosthetic and custom orthotic device coverage
13 shall not be subject to separate financial requirements that
14 are applicable only with respect to that coverage. An
15 individual or group health care plan may impose cost sharing on
16 prosthetic or custom orthotic devices; provided that any cost-
17 sharing requirements shall not be more restrictive than the
18 cost-sharing requirements applicable to the plan's coverage for
19 inpatient physician and surgical services.

20 G. An individual or group health plan that provides
21 coverage for prosthetic or orthotic services shall ensure
22 access to medically necessary clinical care and to prosthetic
23 and custom orthotic devices and technology from not less than
24 two distinct prosthetic and custom orthotic providers in the
25 managed care plan's provider network located in the state. In

.225290.1

1 the event that medically necessary covered orthotics and
2 prosthetics are not available from an in-network provider, the
3 insurer shall provide processes to refer a member to an out-of-
4 network provider and shall fully reimburse the out-of-network
5 provider at a mutually agreed upon rate less member cost
6 sharing determined on an in-network basis.

7 H. If coverage for prosthetic or custom orthotic
8 devices is provided, payment shall be made for the replacement
9 of a prosthetic or custom orthotic device or for the
10 replacement of any part of such devices, without regard to
11 continuous use or useful lifetime restrictions, if an ordering
12 health care provider determines that the provision of a
13 replacement device, or a replacement part of such a device, is
14 necessary because of any of the following:

15 (1) a change in the physiological condition of
16 the patient;

17 (2) an irreparable change in the condition of
18 the device or in a part of the device; or

19 (3) the condition of the device, or the part
20 of the device, requires repairs and the cost of such repairs
21 would be more than sixty percent of the cost of a replacement
22 device or of the part being replaced.

23 I. Confirmation from a prescribing health care
24 provider may be required if the prosthetic or custom orthotic
25 device or part being replaced is less than three years old.

.225290.1

