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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:

"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 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

1 for the comfort or convenience of the enrollee. This
2 coverage shall include all services and supplies necessary
3 for the effective use of a prosthetic or custom orthotic
4 device, including:

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

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

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

12 (4) the repair and replacement of it.

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

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

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

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

3 (4) the repair and replacement of it.

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

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

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

23 G. A group health plan may limit the coverage for,
24 or alter the cost-sharing requirements for, out-of-network
25 coverage of prosthetic and custom orthotic devices; provided

1 that the restrictions and cost-sharing requirements
2 applicable to prosthetic or custom orthotic devices shall not
3 be more restrictive than the restrictions and requirements
4 applicable to the out-of-network coverage for a group health
5 plan's medical and surgical coverage.

6 H. In the event that medically necessary covered
7 orthotics and prosthetics are not available from an in-
8 network provider, the insurer shall provide processes to
9 refer a member to an out-of-network provider and shall fully
10 reimburse the out-of-network provider at a mutually agreed
11 upon rate less member cost sharing determined on an in-
12 network basis.

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

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

24 K. Coverage for prosthetic and custom orthotic
25 devices shall be considered habilitative or rehabilitative

1 benefits for purposes of any state or federal requirement for
2 coverage of essential health benefits, including habilitative
3 and rehabilitative benefits.

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

12 (1) a change in the physiological condition
13 of the patient;

14 (2) an irreparable change in the condition
15 of the device or in a part of the device; or

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

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

23 N. A group health plan subject to the Health Care
24 Purchasing Act shall not discriminate against individuals
25 based on disability, including limb loss, absence or

1 malformation."

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

4 "UNFAIR TRADE PRACTICES ON THE BASIS OF DISABILITY
5 PROHIBITED.--

6 A. Any of the following practices with respect to
7 a health benefits plan are defined as unfair and deceptive
8 practices and are prohibited:

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

12 (2) denying a prosthetic or orthotic benefit
13 for an individual with limb loss or absence that would
14 otherwise be covered for a non-disabled person seeking
15 medical or surgical intervention to restore or maintain the
16 ability to perform the same physical activity;

17 (3) failure to apply the most recent version
18 of treatment and fit criteria developed by the professional
19 association with the most relevant clinical specialty when
20 performing a utilization review for a request for coverage of
21 prosthetic or orthotic benefits; and

22 (4) failure to apply medical necessity
23 review standards developed by the professional association
24 with the most relevant clinical specialty when conducting
25 utilization management review or processing appeals regarding

1 benefit denial.

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

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

1 or

2 (13) any other policy specified in rules of
3 the superintendent."

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

6 "MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR
7 COVERAGE OF PROSTHETICS OR ORTHOTICS.--

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

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

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

25 D. An insurer shall not deny a prosthetic or

1 orthotic benefit for an individual with limb loss or absence
2 that would otherwise be covered for a non-disabled person
3 seeking medical or surgical intervention to restore or
4 maintain the ability to perform the same physical activity.

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

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

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

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

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

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

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

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

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

25 J. The provisions of this section do not apply to

1 excepted benefits plans subject to the Short-Term Health Plan
2 and Excepted Benefit Act."

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

5 "MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR
6 COVERAGE OF PROSTHETICS AND ORTHOTICS.--

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

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

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

24 D. An insurer shall not deny a prosthetic or
25 orthotic benefit for an individual with limb loss or absence

1 that would otherwise be covered for a non-disabled person
2 seeking medical or surgical intervention to restore or
3 maintain the ability to perform the same physical activity.

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

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

18 G. A group health plan that provides coverage for
19 prosthetic or orthotic services shall ensure access to
20 medically necessary clinical care and to prosthetic and
21 custom orthotic devices and technology from not less than two
22 distinct prosthetic and custom orthotic providers in the
23 managed care plan's provider network located in the state.
24 In the event that medically necessary covered orthotics and
25 prosthetics are not available from an in-network provider,

1 the insurer shall provide processes to refer a member to an
2 out-of-network provider and shall fully reimburse the
3 out-of-network provider at a mutually agreed upon rate less
4 member cost sharing determined on an in-network basis.

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

13 (1) a change in the physiological condition
14 of the patient;

15 (2) an irreparable change in the condition
16 of the device or in a part of the device; or

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

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

24 J. The provisions of this section do not apply to
25 excepted benefits plans subject to the Short-Term Health Plan

1 and Excepted Benefit Act."

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

4 "MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR
5 COVERAGE OF PROSTHETICS AND ORTHOTICS.--

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

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

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

24 D. An insurer shall not deny a prosthetic or
25 orthotic benefit for an individual with limb loss or absence

1 that would otherwise be covered for a non-disabled person
2 seeking medical or surgical intervention to restore or
3 maintain the ability to perform the same physical activity.

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

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

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

1 network provider, the insurer shall provide processes to
2 refer a member to an out-of-network provider and shall fully
3 reimburse the out-of-network provider at a mutually agreed
4 upon rate less member cost sharing determined on an in-
5 network basis.

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

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

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

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

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

25 J. The provisions of this section do not apply to

1 excepted benefits plans subject to the Short-Term Health Plan
2 and Excepted Benefit Act."

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

5 "MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR
6 COVERAGE OF PROSTHETICS AND ORTHOTICS.--

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

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

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

25 D. An insurer shall not deny a prosthetic or

1 orthotic benefit for an individual with limb loss or absence
2 that would otherwise be covered for a non-disabled person
3 seeking medical or surgical intervention to restore or
4 maintain the ability to perform the same physical activity.

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

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

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

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

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

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

17 (2) an irreparable change in the condition
18 of 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.

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

SECTION 7. EFFECTIVE DATE.--The effective date of the
provisions of this act is January 1, 2024. _____