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

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

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

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

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

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

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

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

malformation."

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

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

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

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

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

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

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

benefit denial.

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

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

(7) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy;

or

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

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

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

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

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

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

D. An insurer shall not deny a prosthetic or

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

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

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual 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 coverage for inpatient physician and surgical services.

G. A health plan that provides coverage for prosthetic or orthotic services shall ensure 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 network located in the state. In the event that medically necessary covered orthotics and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. A group health plan that provides coverage for prosthetic or orthotic services shall ensure 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 network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group 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 coverage for inpatient physician and surgical services.

G. An individual or group health plan that provides coverage for prosthetic or orthotic services shall ensure 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 network located in the state. In the event that medically necessary covered orthotics and prosthetics are not available from an in-

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

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

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

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

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

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

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

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

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

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

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

D. An insurer shall not deny a prosthetic or

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

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

F. Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group health care 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 coverage for inpatient physician and surgical services.

G. An individual or group health plan that provides coverage for prosthetic or orthotic services shall ensure 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 network located in the state. In the event that medically necessary covered

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

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

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

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

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

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

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.