FISCAL IMPACT REPORT

		LAST UPDATED	03/08/2023
SPONSOR	House Floor	**ORIGINAL DATE**	03/06/2023
SHORT TITLE	Prosthetic and Custom Orthotic Device Coverage	**BILL NUMBER**	HFlS/House Bill 131/HFlS
		ANALYST	Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
NMPSIA added costs		$75.0	$250.0	$325.0	Recurring	General Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent version of this legislation.

Sources of Information

LFC Files

Responses Received From the Following, Regarding the Original Bill
Office of the Superintendent of Insurance (OSI) (revised to address substitute)
Public School Insurance Authority (PSIA)
General Services Department (GSD)
Retiree Health Care authority (RHCA)
Human Services Department (HSD)

No Response Received
Albuquerque Public Schools (APS)

SUMMARY

Synopsis of House Floor Substitute for House Bill 131

House Bill 131, Prosthetic and Custom Orthotic Device Coverage, requires certain health insurance products marketed in New Mexico under the Health Care Purchasing Act, to cover expenses related to prosthetic and custom orthotic devices for patients to at least the same extent as is covered by the Medicare program and at least as favorable as the plan's medical and surgical benefits. It prohibits unfair trade practices on the basis of disability.

Section 1 of the bill applies the following requirements to group health coverage under the Health Care Purchasing Act:

- They must cover prosthetic and custom orthotic devices for patients to at least the same

extent as is covered by the Medicare program and at least as favorable as the plan's medical and surgical benefits.

- They must cover the most appropriate prosthesis or custom orthotic device prescribed by the patient's medical provider to provide for the patient's daily activities and job-related activities, not just the patient's comfort and convenience.
- All portions of the provision of the device must be covered, including fabrication and supplies needed for fabrication, instruction on its use, and repair and replacement of the device.
- If necessary orthotics or prosthetics are not available through a network provider, a method for referral to an out-of-network provider must be in place. That provider and the insurer must come to agreement on the price of the provider's services, minus the coinsurance required of the patient.
- They must cover prosthetics or custom orthotic devices necessary for physical exercise, including running, bicycling and swimming, including all aspects of provision of the device as in the point above.
- Rate of reimbursement should be no less than the federal Medicare reimbursement rate and no more restrictive than other coverage under the plan.
- Cost-sharing for prosthetics and custom orthotics cannot be higher than cost-sharing for other parts of the patient's coverage.
- Coverage limitations or cost-sharing for custom orthotic or prosthetic devices provided by out-of-network providers can be no more restrictive than the plan's other out-of-network requirements.
- There cannot be a lower annual or lifetime limit for orthotics or prosthetics that is lower than for total services under the plan.
- If in a managed care organization, a patient must have access to at least two providers of prosthetics and custom orthotics.
- Coverage for these products is to be considered habilitative or rehabilitative benefits for any state or federal requirements of coverage of health benefits.
- Replacement of orthotic or prosthetic devices must be covered if covered for the device(s) prior to need for replacement, on the basis of a change in the patient's need, a change in the condition of the device or a piece of the device, or because repairs are needed that would cost more than 60 percent of the cost of a replacement device or part of a device.

Section 2 of the bill defines as prohibited unfair practices:

- Canceling or changing the premiums of a person on the basis of a disability.
- Denying prosthetics or orthotics to individuals with limb loss or absence if covered for others without limb loss or absence.
- Failing to use updated treatment and fit criteria developed by the most relevant professional organization during the insurer's utilization review or during benefit denial.

The following exceptions to application of Section 2 are listed as accident-only policies, credit-only policies, long- or short-term disability policies, disease-specific policies, coverage provided through Titles 18 or 19 of the Social Security Act, Federal TRICARE policies, fixed or hospital indemnity policies, dental policies, vision-only policies, worker's compensation policies, automobile medical payment policies, and any other policies specified by the superintendent of insurance.

Section 3 of the bill adds the same provisions to Section 59A-22 NMSA 1978 of the New Mexico Insurance Code, having to do with individual health plans, except those plans subject to the Short-Term Health Plan and Excepted Benefits Act. For replacement of orthotic or prosthetic devices less than three years old, a prescriber's assent may be needed.

Section 4 of the bill applies the same requirements to Section 59A-23 NMSA 1978, having to do with group health plans, except those plans subject to the Short-Term Health Plan and Excepted Benefits Act. For replacement of orthotic or prosthetic devices less than three years old, a prescriber's assent may be needed.

Section 5 applies the same requirements to health maintenance organization contracts, except those plans subject to the Short-Term Health Plan and Excepted Benefits Act, in a new subsection of Section 59A-46 NMSA 1978. For replacement of orthotic or prosthetic devices less than three years old, a prescriber's assent may be needed.

Section 6 applies the same requirements to non-profit health plans, except those plans subject to the Short-Term Health Plan and Excepted Benefits Act, in a new subsection of Section 59A-46 NMSA 1978. For replacement of orthotic or prosthetic devices less than three years old, a prescriber's assent may be needed.

The effective date of this bill is January 1, 2024 (Section 7 of the bill).

FISCAL IMPLICATIONS

There is no appropriation in House Bill 131.

RHCA indicates that it already provides insurance coverage for prosthetics and custom orthotics and therefore the bill would have no fiscal impact on that agency. GSD indicates that it will also not see increased costs relative to this bill's provisions.

PSIA, on the other hand, calculates a potential cost to that agency related to the bill:

> Public Schools Insurance Authority (PSIA) currently covers prosthetics and functional orthotics under the benefit for Durable Medical Equipment (DME). Coverage is subject to cost-sharing…
> Estimated fiscal impacts noted above are based upon a review of PSIA's historical experience for prosthetics and functional orthotics. The estimates include induced utilization to reflect the expectation that members may now purchase a custom orthotic device where they may have previously elected for a less expensive off-the-shelf orthotic.
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> Historical PSIA utilization indicates an average of approximately four claims per 1,000 members for custom orthotics or prosthetics with average cost of about $750. The cost range of more expensive custom prosthetics is notably higher (average cost of about $5,000) with lower utilization (0.5 claims per 1,000 members).
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> The estimated impact in FY24 represents a partial year impact of approximately $75 thousand, with the impact in FY25 and beyond increasing to roughly $250 thousand annually.

OSI states that "This version of the bill eliminates any fiscal impact on the Office of the Superintendent of Insurance and potential requirement that the state must defray the cost of mandated benefits on individuals covered by the New Mexico health insurance exchange."

SIGNIFICANT ISSUES

OSI describes orthotics and prosthetic devices in the following way:

> Prosthetic devices are artificial devises that replace or augment a missing or impaired part of the body. The purchase, fitting, and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are covered when they replace a limb or other part of the body, after accidental or surgical removal and/or when the body's growth necessitates replacement.
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> Examples of prosthetic devices include, but are not limited to:
> • Breast prostheses when required because of mastectomy and prophylactic mastectomy
> • Artificial limbs
> • Prosthetic eye
> • Prosthodontic appliances
> • Penile prosthesis
> • Joint replacements
> • Heart pacemakers
> • Tracheostomy tubes and cochlear implants
>
> Covered orthotic appliances include:
> - Podiatric appliances for prevention of feet complications associated with diabetes.
> - Braces and other external devises used to correct a body function including clubfoot deformity.
> - Foot orthotics or shoe appliances as for diabetic neuropathy or other significant neuropathy.

It is clear from these non-inclusive examples that these quite disparate items are essential for continued life and activity.

HSD notes that "Each Medicaid Managed Care Organization has at least two prosthetic and orthotic providers." HSD also notes that Medicaid already covers orthotics and prosthetics.

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