



House of Representatives

General Assembly

File No. 93

January Session, 2009

Substitute House Bill No. 5093

House of Representatives, March 19, 2009

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PROSTHETIC PARITY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2010*) (a) As used in this
2 section:

3 (1) "Health insurance policy" means any individual health insurance
4 policy or medical or health care benefit plan that is delivered, issued
5 for delivery, renewed, amended or continued in this state by an
6 insurer, health care center, hospital service corporation, medical
7 service corporation, fraternal benefit society, or governmental entity
8 that provides medical benefits to Medicaid, HUSKY Plan, Charter Oak
9 Health Plan or state-administered assistance recipients.

10 (2) "Prosthetic device" means an artificial limb device to replace, in
11 whole or in part, an arm or a leg, except that it does not include a
12 device that contains a microprocessor or that is designed exclusively
13 for athletic purposes.

14 (b) (1) Each individual health insurance policy providing coverage
15 of the types specified in subdivisions (1), (2), (4), (11) and (12) of
16 section 38a-469 of the general statutes shall provide coverage for
17 prosthetic devices that is at least equivalent to that provided under
18 Medicare. Such coverage may be limited to a prosthetic device that is
19 determined by the insured's or enrollee's health care provider to be the
20 most appropriate to meet the medical needs of the insured or enrollee.
21 Such prosthetic device shall not be considered durable medical
22 equipment under such policy.

23 (2) Such policy shall provide coverage for the medically necessary
24 repair or replacement of a prosthetic device, as determined by the
25 insured's or enrollee's health care provider, unless such repair or
26 replacement is necessitated by misuse or loss.

27 (3) No such policy shall impose a coinsurance, copayment,
28 deductible or other out-of-pocket expense for a prosthetic device that is
29 more restrictive than that imposed on substantially all other benefits
30 provided under such policy, except that a high deductible health plan,
31 as that term is used in subsection (f) of section 38a-520 of the general
32 statutes, shall not be subject to the deductible limits set forth in this
33 subdivision or under Medicare pursuant to subdivision (1) of this
34 subsection.

35 (c) An individual health insurance policy may require prior
36 authorization for prosthetic devices, provided it is required in the
37 same manner and to the same extent as is required for other covered
38 benefits under such policy.

39 (d) An insured or enrollee may appeal a denial of coverage for or
40 repair or replacement of a prosthetic device to the Insurance
41 Commissioner for an external, independent review pursuant to section
42 38a-478n of the general statutes.

43 Sec. 2. (NEW) (*Effective January 1, 2010*) (a) As used in this section:

44 (1) "Health insurance policy" means any group health insurance

45 policy or medical or health care benefit plan that is delivered, issued
46 for delivery, renewed, amended or continued in this state by an
47 insurer, health care center, hospital service corporation, medical
48 service corporation, fraternal benefit society, or governmental entity
49 that provides medical benefits to Medicaid, HUSKY Plan, Charter Oak
50 Health Plan or state-administered assistance recipients.

51 (2) "Prosthetic device" means an artificial limb device to replace, in
52 whole or in part, an arm or a leg, except that it does not include a
53 device that contains a microprocessor or that is designed exclusively
54 for athletic purposes.

55 (b) (1) Each group health insurance policy providing coverage of the
56 types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
57 469 of the general statutes shall provide coverage for prosthetic devices
58 that is at least equivalent to that provided under Medicare. Such
59 coverage may be limited to a prosthetic device that is determined by
60 the insured's or enrollee's health care provider to be the most
61 appropriate to meet the medical needs of the insured or enrollee. Such
62 prosthetic device shall not be considered durable medical equipment
63 under such policy.

64 (2) Such policy shall provide coverage for the medically necessary
65 repair or replacement of a prosthetic device, as determined by the
66 insured's or enrollee's health care provider, unless such repair or
67 replacement is necessitated by misuse or loss.

68 (3) No such policy shall impose a coinsurance, copayment,
69 deductible or other out-of-pocket expense for a prosthetic device that is
70 more restrictive than that imposed on substantially all other benefits
71 provided under such policy, except that a high deductible health plan,
72 as that term is used in subsection (f) of section 38a-520 of the general
73 statutes, shall not be subject to the deductible limits set forth in this
74 subdivision or subdivision (1) of this subsection.

75 (c) A group health insurance policy may require prior authorization
76 for prosthetic devices, provided it is required in the same manner and

77 to the same extent as is required for other covered benefits under such
78 policy.

79 (d) An insured or enrollee may appeal a denial of coverage for or
80 repair or replacement of a prosthetic device to the Insurance
81 Commissioner for an external, independent review pursuant to section
82 38a-478n of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2010	New section
Sec. 2	January 1, 2010	New section

Statement of Legislative Commissioners:

In sections 1(b)(3) and 2(b)(3), "substantially all other benefits" was substituted for "generally all benefits" for clarity, in section 1(b)(3), "under Medicare pursuant to" was added for clarity and, in sections 1 and 2, references to "Charter Oak Health Plan" were revised for accuracy.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact:

Municipalities	Effect	FY 10 \$	FY 11 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

This mandate is not anticipated to impact the state employee and retiree health plan as current coverage either meets or exceeds the benefit level required. There is also no anticipated impact for the Department of Social Services as the HUSKY, Medicaid, State Administered General Assistance and Charter Oak programs already provide prosthetic coverage that meets the requirements of the bill.

This bill requires a health insurance policy to provide coverage of prosthetic devices, defined as artificial limbs, at least equal to the coverage Medicare provides for such devices. Currently Medicare covers 80% of the cost after the member pays an annual \$135 deductible. The bill requires a plan to cover repairs or replacement to prosthetic devices, excluding misuse or loss. Prior authorization and copayments are permitted, provided they are no more restrictive than those imposed on other policy benefits. Current law allows insured participants to appeal denial of coverage with the insurance commissioner.

The mandate's provisions may increase costs to certain fully insured municipal plans which do not currently provide the required coverage of the prosthetic devices. The coverage requirements may result in

increased premium costs when municipalities enter into new health insurance contracts after January 1, 2010. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The Out Years

As previously stated, the bill's coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2010. The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Office of the State Comptroller, Medicare website, Municipal Employees Health Insurance Plan (MEHIP) Schedule of Benefits, State Employee Health Plan Subscriber Agreement.

OLR Bill Analysis**sHB 5093*****AN ACT CONCERNING PROSTHETIC PARITY.*****SUMMARY:**

This bill requires a health insurance policy to cover prosthetic devices, and repairs and replacements to them, subject to specified conditions. It defines a "prosthetic device" as an artificial device to replace all or part of an arm or leg. It excludes a device that (1) contains a microprocessor or (2) is designed exclusively for athletic purposes.

Under the bill, the coverage must be at least equivalent to the coverage Medicare provides for such devices, but may be limited to a prosthetic device that the person's health care provider determines is most appropriate to meet his or her medical needs. (Medicare covers 80% of the cost of prostheses, after a person pays his or her annual deductible.)

The bill prohibits a policy from considering a prosthetic device as durable medical equipment. (Thus, the amount covered cannot count toward a durable medical equipment maximum.)

The bill applies to a policy, among others (see below), that a government entity issues covering Medicaid, HUSKY Plan, Charter Oak Health Plan, or state-administered assistance recipients by including these plans in the definition of "health insurance policy." (It is unclear how this requirement will be implemented or enforced, as these plans are not under the Insurance Department's jurisdiction.)

EFFECTIVE DATE: January 1, 2010

ADDITIONAL COVERAGE REQUIREMENTS

The bill requires a policy to cover repairs to or replacements of prosthetic devices that the person's health care provider determines are medically necessary. It excludes coverage of repairs or replacements needed because of misuse or loss of the device.

The bill permits a person who is denied coverage for a prosthetic device, or device repair or replacement, to file an external appeal with the insurance commissioner in accordance with law.

The bill prohibits a policy from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on most other policy benefits. It specifies that this prohibition does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

The bill permits a policy to require prior authorization for prosthetic devices, but only in the same manner and to the same extent as prior authorization is required for other policy benefits.

APPLICABILITY

The bill applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services that are delivered, issued, renewed, amended, or continued in Connecticut by an:

1. insurer;
2. health care center (i.e., HMO);
3. hospital or medical service corporation;
4. fraternal benefit society; or
5. government entity covering Medicaid, HUSKY Plan, Charter Oak Health Plan, or state-administered assistance recipients.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Medically Necessary

The law defines “medically necessary” as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient’s illness, injury, or disease;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

“Generally accepted standards of medical practice” means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment.

External Appeal to Commissioner

The law allows a person, or provider on his behalf, who has exhausted a health insurer’s, managed care organization’s (MCO), or utilization review (UR) company’s internal appeal process to appeal to the insurance commissioner any claim denial based on medical necessity or decision not to certify an admission, service, procedure, or extension of stay.

The person or provider must submit the “external appeal” within 60 days of receiving a final determination from the insurer, MCO, or UR company to the commissioner on forms he prescribes. The appeal must include a general release for the person’s medical records and a \$25 processing fee, which the commissioner can waive for an indigent person. The company against who the appeal is filed must also pay a \$25 fee. The commissioner assigns the appeal to an independent entity for review and a binding decision. The commissioner refunds (1) the company’s fee if, after an initial review, the appeal is not accepted for a full review or (2) the prevailing party’s fee after completing a full review.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18 Nay 1 (03/03/2009)