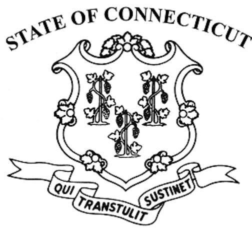

Senate

General Assembly

File No. 335

February Session, 2018

Senate Bill No. 376

Senate, April 9, 2018

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PROSTHETIC DEVICES.

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

1 Section 1. (NEW) (*Effective January 1, 2019*) (a) As used in this
2 section, "prosthetic device" means an artificial limb device to replace,
3 in whole or in part, an arm or a leg, including a device that contains a
4 microprocessor if such microprocessor-equipped device is determined
5 by the insured's or enrollee's health care provider to be medically
6 necessary. "Prosthetic device" does not include a device that is
7 designed exclusively for athletic purposes.

8 (b) (1) Each individual health insurance policy providing coverage
9 of the types specified in subdivisions (1), (2), (4), (11) and (12) of
10 section 38a-469 of the general statutes delivered, issued for delivery,
11 renewed, amended or continued in this state shall provide coverage
12 for prosthetic devices that is at least equivalent to that provided under
13 Medicare. Such coverage may be limited to a prosthetic device that is

14 determined by the insured's or enrollee's health care provider to be the
15 most appropriate to meet the medical needs of the insured or enrollee.
16 Such prosthetic device shall not be considered durable medical
17 equipment under such policy.

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

22 (3) No such policy shall impose a coinsurance, copayment,
23 deductible or other out-of-pocket expense for a prosthetic device that is
24 more restrictive than that imposed on substantially all other benefits
25 provided under such policy, except that a high deductible plan, as that
26 term is used in subsection (f) of section 38a-493 of the general statutes,
27 shall not be subject to the deductible limits set forth in this subdivision
28 or under Medicare pursuant to subdivision (1) of this subsection.

29 (c) An individual health insurance policy may require prior
30 authorization for prosthetic devices, provided such authorization is
31 required in the same manner and to the same extent as is required for
32 other covered benefits under such policy.

33 Sec. 2. (NEW) (*Effective January 1, 2019*) (a) As used in this section,
34 "prosthetic device" means an artificial limb device to replace, in whole
35 or in part, an arm or a leg, including a device that contains a
36 microprocessor if such microprocessor-equipped device is determined
37 by the insured's or enrollee's health care provider to be medically
38 necessary. "Prosthetic device" does not include a device that is
39 designed exclusively for athletic purposes.

40 (b) (1) Each group health insurance policy providing coverage of the
41 types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
42 469 of the general statutes delivered, issued for delivery, renewed,
43 amended or continued in this state shall provide coverage for
44 prosthetic devices that is at least equivalent to that provided under
45 Medicare. Such coverage may be limited to a prosthetic device that is

46 determined by the insured's or enrollee's health care provider to be the
47 most appropriate to meet the medical needs of the insured or enrollee.
48 Such prosthetic device shall not be considered durable medical
49 equipment under such policy.

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

54 (3) No such policy shall impose a coinsurance, copayment,
55 deductible or other out-of-pocket expense for a prosthetic device that is
56 more restrictive than that imposed on substantially all other benefits
57 provided under such policy, except that a high deductible plan, as that
58 term is used in subsection (f) of section 38a-520 of the general statutes,
59 shall not be subject to the deductible limits set forth in this subdivision
60 or under Medicare pursuant to subdivision (1) of this subsection.

61 (c) A group health insurance policy may require prior authorization
62 for prosthetic devices, provided such authorization is required in the
63 same manner and to the same extent as is required for other covered
64 benefits under such policy.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section

INS *Joint Favorable*

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:

Agency Affected	Fund-Effect	FY 19 $	FY 20 $
The State	Other - Cost	Up to $600,000	Up to $1.2 million

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

Explanation

The bill does not result in a cost to the state employee and retiree health plan as the plan currently complies with the coverage requirements of the bill. The bill will result in a cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) of up to $600,000 in FY 19 and $1.2 million in FY 20 related to coverage of prosthetic repairs and replacements as required by the bill.[1]

The bill will increase costs to certain fully-insured municipal plans that do not currently provide coverage for prosthetic devices in accordance with the bill. The coverage requirements will result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2019. In addition, many municipal health plans are recognized as "grandfathered" health plans under the

[1] *Review and Evaluation of Public Act 09-188, An Act Concerning Wellness Programs and Expansion of Health Insurance Coverage*. UConn Center Public Health and Health Care Policy (2009).

ACA.[2] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs), include a federally defined essential health benefits package (EHB). While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan. Coverage of repairs and replacements of prosthetics in accordance with the bill are in excess of the benchmark plan. Neither the agency nor the mechanism for the state to pay these costs has been specified.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to various factors and for fully-insured municipalities, will be reflected in future premiums.

[2] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Generally, grandfathered plans are not required to provide coverage for EHBs.

OLR Bill Analysis

SB 376

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PROSTHETIC DEVICES.

SUMMARY

This bill requires certain health insurance policies to cover prosthetic devices, and medically necessary 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, including one with a microprocessor if the patient's health care provider determines it is medically necessary. It excludes a device that is designed exclusively for athletic purposes.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2019

PROSTHETIC DEVICES

Coverage Required

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

The bill also requires policies to cover repairs or replacements of prosthetic devices that the patient's health care provider determines are medically necessary, but not those needed because of misuse or loss.

Out-of-Pocket Expenses

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. However, the prohibition concerning deductibles does not apply to high deductible plans designed to be compatible with federally qualified health savings accounts.

Durable Medical Equipment

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

Prior Authorization

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

BACKGROUND

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148, § 1311(d)(3)), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required essential health benefits, provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. The state must pay the insurance carrier or enrollee to defray the cost of any new benefits it mandates after that date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 21 Nay 0 (03/20/2018)