Ohio Legislative Service Commission

Bill Analysis

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H.B. 310

128th General Assembly
(As Introduced)

Reps. Garland and Driehaus, Murray, Hagan, Chandler, Okey, Stewart, Celeste, Harris, Harwood, Domenick, Fende, Brown, Yuko, Letson, B. Williams, Phillips, Pillich, Ujvagi

BILL SUMMARY

- Requires health insurers to provide coverage for certain prostheses.

CONTENT AND OPERATION

Prostheses coverage

(R.C. 1739.05, 1751.69, and 3923.85)

The bill requires (1) individual and group health insuring corporation policies, contracts, and agreements, (2) individual and group policies of sickness and accident insurance, (3) public employee benefit plans, and (4) multiple employer welfare arrangements to provide coverage for a prosthetic leg, arm, or eye that at least equals the coverage provided by the federal Medicare program (see **COMMENT**).[1] The bill further requires coverage of (1) a replacement prosthesis, if there is a change in the patient's physical condition, or (2) repair to, or replacement of, a prosthesis, if the patient's treating physician determines that the repair or replacement is appropriate.

The bill permits health insurers to require prior authorization for a prosthesis in the same manner that prior authorization is required for any other covered benefit.

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[1] The bill does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare supplement, Medicare, Tricare, long-term care, disability income, one-time limited duration policy of not longer than six months, or other policy that offers only supplemental benefits (R.C. 3923.85(H)).

Covered benefits are to be limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the patient's treating physician.

The bill permits health insurers to impose a copayment, coinsurance, or both, on a prosthesis, but it is not to exceed the copayment or coinsurance amounts imposed under the Medicare Part B fee-for-service system.[2] The insurers are to reimburse for a prosthesis at an amount not less than the fee schedule amount for the prosthesis under the federal Medicare reimbursement schedule. The insurers are prohibited from imposing any annual or lifetime dollar maximum on coverage for prostheses other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the policy, contract, agreement, plan, or arrangement.

The bill specifies that the coverage requirement applies regardless of the existing law provisions under which new health insurance mandates are not to be applied unless the Superintendent of Insurance determines the mandate can be applied fully and equally in all respects to employee benefit plans subject to regulation under the federal Employee and Retirement Income and Security Act (ERISA).[3]

COMMENT

According to the United States Department of Health and Human Services, Medicare generally covers prosthetic devices needed to replace an internal body part or function, including Medicare-approved corrective lenses needed after a cataract operation, ostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medicare also covers artificial limbs and eyes, and arm, leg, back, and neck braces. Medicare does not pay for (1) orthopedic shoes, unless they are a necessary part of the leg brace and the cost is included in the charge for the brace, or (2) dental plates or other dental devices.[4]

After paying an annual deductible ($135 in 2009) for Medicare Part B services and supplies, Medicare beneficiaries are responsible for paying 20% of Medicare-

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[2] Medicare Part B covers outpatient services and supplies, as opposed to Part A, which covers hospitalization. Medicare Part C provides for coverage through managed care plans, known as Medicare Advantage plans, and thereby differs from the fee-for-service reimbursement system used in Medicare Parts A and B.

[3] ERISA applies to employer-sponsored health insurance plans under which the employer self-insures. Because of federal preemption, states have little authority to regulate these plans.

[4] U.S. Department of Health and Human Services, Centers for Medicare and Medicare and Medicaid Services; information available at <http://www.medicare.gov/Coverage/Home.asp>, last visited October 27, 2009.

approved amounts for the services and supplies. Actual amounts may be higher if a doctor, health care provider, or supplier does not accept assignment, which is an agreement to accept the Medicare-approved amount as full payment.[5]

HISTORY

ACTION	DATE
Introduced	10-13-09

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[5] *Id*.