Ohio Legislative Service Commission

Bill Analysis

Laura Gengo

Sub. H.B. 310

128th General Assembly
(As Reported by H. Health)

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 medically necessary prostheses.

CONTENT AND OPERATION

Prostheses coverage

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

The bill requires certain health insurers to provide coverage for benefits for the following types of prostheses: artificial legs, arms, and eyes. The coverage extends to a prosthesis replacement if required because of a change in the patient's physical condition.

The following types of health insurers are subject to the bill's requirements:

(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;

(4) Multiple employer welfare arrangements.

Coverage specifications

All of the following apply to the coverage of prostheses under the bill:

--Medical necessity: The coverage is required for prostheses that are medically necessary.[1]

--Medicare equivalency: The coverage must be at least equal to the coverage provided under the federal Medicare program (*see* **COMMENT**).

--Repair or replacement: The coverage must extend to the repair or, as specified above, the replacement of a prosthesis. The repair or replacement must be medically necessary.[2]

--Prior authorization: The health insurer may require prior authorization for a prosthesis using the same prior authorization process that is used for other covered benefits.

--Cost sharing: The health insurer may impose a deductible, copayment, or coinsurance, or any combination thereof. The amount imposed cannot exceed the respective amount that is imposed for other health benefits.

--Reimbursement rate: The reimbursement provided by the health insurer must be in an amount equal to Medicare's fee schedule amount for the prosthesis.

--Maximum limits: The health insurer cannot impose any annual or lifetime dollar maximum on the coverage, other than an annual or lifetime maximum that applies in the aggregate to all terms and services covered under the same policy, contract, agreement, plan, or arrangement.

Reimbursement exclusions for non-contracting providers

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

The bill specifies that it does not require a health insurer to provide reimbursement to a health care provider or facility for providing, repairing, or replacing prostheses if the provider or facility does not have a health care contract with the health insurer.

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[1] The bill does not specify the entity that is responsible for determining whether a prosthesis is medically necessary.

[2] *Id*.

Exclusion of Medicaid managed care contracts and other insurance policies

(R.C. 1751.69(D) and 3923.85(D))

In the case of health insuring corporations, the bill provides that it does not apply to a contract that a health insuring corporation enters into with the Department of Job and Family Services for purposes of the Medicaid managed care system.

In the case of sickness and accident insurers, the bill provides that it 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.

Inapplicability of limits on new mandated benefits

(R.C. 3901.71 (not in the bill); R.C. 1751.69(B) and 3923.85(B))

The bill specifies that its required coverage of prostheses applies regardless of the provisions of existing law under which new health insurance mandates are not to be applied unless the Superintendent of Insurance determines that 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]

Effective date of coverage

(Section 3)

The bill specifies that its provisions apply only to policies, contracts, agreements, plans, or arrangements that are delivered, issued for delivery, renewed, established, or modified on or after the bill's effective date.

COMMENT

According to the United States Department of Health and Human Services, the Medicare program covers artificial limbs and eyes, as well as 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

[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.

breast prostheses (including a surgical brassiere) after a mastectomy. Medicare also covers 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 ($155 in 2010) for Medicare Part B[5] services and supplies, Medicare beneficiaries are responsible for paying 20% of Medicare-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.[6]

HISTORY

ACTION	DATE
Introduced	10-13-09
Reported, H. Health	05-27-10

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[4] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; *Your Medicare Benefits*, available at <http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>.

[5] Medicare Part B covers outpatient services and supplies, as opposed to Medicare Part A, which covers hospitalization.

[6] *Your Medicare Benefits*.