BILL ANALYSIS

C.S.H.B. 223
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Insured families in need of prosthetic or orthotic devices are facing benefit caps, lifetime benefit caps, or the complete elimination of prosthetic or orthotic device coverage. Currently, insurance companies are authorized to limit or exclude prosthetic or orthotic device coverage in a health benefit plan. A growing number of group and private insurance companies cap benefits for such devices to the extent that the average working family is unable to afford the cost of a prosthetic or orthotic device. For example, many insurance policies limit coverage to $2,500 or less per year, whereas the average cost of a basic below-the-knee prosthetic costs $7,500, and the average cost for a basic above-the-knee prosthetic is $13,000. Lifetime caps impact insured families with children who have lost a limb, in particular, because it becomes necessary to purchase replacement prosthetics to accommodate the child as he or she grows.

As proposed, C.S.H.B. 223 requires certain health benefit plans to provide coverage for prosthetic and orthotic devices and services relating thereto equal to that of Medicare benefit levels to ensure that Texans who are medically insured are protected in the event of limb loss.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 223 relates to health benefit plan coverage for certain prosthetic devices, orthotic devices, and related services.

First, C.S.H.B. 223 in SECTION 1 seeks to amend Subtitle E, Title 8 of the Texas Insurance Code by adding Chapter 1371, which discusses coverage for certain prosthetic devices, orthotic devices, and related services. Section 1371.001 of the substitute sets out definitions. C.S.H.B. 223 first defines an "enrollee" as an individual entitled to coverage under a health benefit plan. "Orthotic device" is a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. "Prosthetic device" means an artificial device designed to replace, wholly or partly, an arm or a leg.

Next, C.S.H.B. 223, in SECTION 1, discusses the applicability of the chapter. Section 1371.002 states that this chapter applies only to a health plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy, or insurance agreement, or a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by: an insurance company, a group hospital service corporation operating under Chapter 842, a fraternal benefit society operating under Chapter 885, a stipulated premium company operating under Chapter 884, a reciprocal exchange operating under Chapter 942, a Lloyd's plan operating under Chapter 941, a health maintenance organization operating under Chapter 843, a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 or an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. Notwithstanding Section 172.014 of the Local Government Code, or any other law, this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172 of the Local Government Code. Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to: a basic coverage plan under Chapter 1551, a basic plan

under Chapter 1575, a primary care coverage plan under Chapter 1579 and basic coverage under Chapter 1601.

In SECTION 1, Section 1371.003, C.S.H.B. 223 requires coverage for prosthetic devices, orthotic devices, and related services. The committee substitute states that a health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable. The section goes on to say that covered benefits under this chapter are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the enrollee as determined by the enrollee's treating physician or podiatrist and prosthetist or orthotist, as applicable. Also, subject to applicable copayments and deductibles, the repair and replacement of a prosthetic device or orthotic device is a covered benefit under this chapter unless the repair or replacement is necessitated by misuse or loss by the enrollee. Coverage required under this section: must be provided in a manner determined to be appropriate in consultation with the treating physician or podiatrist and prosthetist or orthotist, as applicable, and the enrollee; may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and maybe not be subject to annual dollar limits.

Next, C.S.H.B. 223 in SECTION 1, Section 1371.003(e) states that covered benefits under this chapter may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services. This chapter does not preclude a pharmacy from being reimbursed by a health benefit plan for the provision of orthotic services.

C.S.H.B. 223 in SECTION 1, Section 1371.004 discusses preauthorization and states that a health benefit plan may require prior authorization for a prosthetic device or an orthotic device in the same manner that the health benefit plan requires prior authorization for any other covered benefit. Next, Section 1371.005 of C.S.H.B. 223 discusses managed care plan and states that a health benefit plan provider may require that, if coverage is provided through a managed care plan, the benefits mandated under this chapter are covered benefits only if the prosthetic devices or orthotic devices are provided by a vendor or a provider, and related services are rendered by a provider, that contracts with or is designated by the health benefit plan provider. If the health benefit plan provider provides in-network and out-of-network services, the coverage for prosthetic devices or orthotic devices provided through out-of-network services must be comparable to that provided through in-network services.

SECTION 2 of C.S.H.B. 223 states that Chapter 1371 of the Texas Insurance Code as added by this Act, applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2008, is covered by the law in effect at the time the plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

Finally, SECTION 3 of C.S.H.B. 223 states that this Act takes effect September 1, 2007.

EFFECTIVE DATE

September 1, 2007.

COMPARISON OF ORIGINAL TO SUBSTITUTE

C.S.H.B. 223 makes several changes to the original house bill. First, in SECTION 1, C.S.H.B. 223 removes Subsection (d) in Section 1371.002 as found in the original house bill, which stated that "Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this chapter."

Next, in SECTION 1, C.S.H.B. 223 adds "or podiatrist" to Section 1371.003(b) of the original house bill. Thus, Section 1371.003(b), as found in C.S.H.B. 223, now reads that "Covered

benefits under this chapter are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the enrollee as determined by the enrollee's treating physician or podiatrist and prosthetist or orthotist, as applicable."

In SECTION 1, C.S.H.B. 223 adds "or podiatrist" to Section 1371.003(d)(1). Next, C.S.H.B. 223 adds a new subsection to Section 1371.003 which was not added in the original house bill. Subsection (e), as found in C.S.H.B. 223, now states that covered benefits under this chapter may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services. This chapter does not preclude a pharmacy from being reimbursed by a health benefit plan for the provision of orthotic services.

Finally, in SECTION 1, C.S.H.B. 223 adds "or a provider" to Section 1371.005 of the original house bill. The section, as found in C.S.H.B. 223, reads "A health benefit plan provider may require that, if coverage is provided through a managed care plan, the benefits mandated under this chapter are covered benefits only if the prosthetic devices or orthotic devices are provided by a vendor or a provider, and related services are rendered by a provider, that contracts with or is designated by the health benefit plan provider. If the health benefit plan provider provides in-network and out-of-network services, the coverage for prosthetic devices or orthotic devices provided through out-of-network services must be comparable to that provided through in-network services."