# BILL ANALYSIS

Senate Research Center
80R1282 PB-F

S.B. 54
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## AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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, S.B. 54 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

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

## SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle E, Title 8, Insurance Code, by adding Chapter 1371, as follows:

CHAPTER 1371. COVERAGE FOR CERTAIN PROSTHETIC DEVICES, ORTHOTIC DEVICES, AND RELATED SERVICES

Sec. 1371.001. DEFINITIONS. Defines "enrollee," "orthotic device," and "prosthetic device."

Sec. 1371.002. APPLICABILITY OF CHAPTER. Specifies the health benefit plans to which the chapter applies.

Sec. 1371.003. REQUIRED COVERAGE FOR PROSTHETIC DEVICES, ORTHOTIC DEVICES, AND RELATED SERVICES. (a) Requires a health benefit plan to provide coverage for prosthetic and orthotic devices, and professional services relating to the fitting and use thereof. Requires that such coverage be equal to that provided under certain federal laws for health insurance for the aged and disabled.

(b) Provides that coverage under this chapter is limited to the most appropriate model of prosthetic or orthotic device to meet the needs of the enrollee, as determined by the treating physician, prosthetist, or orthotist.

(c) Requires the coverage under this section to be provided in a specific manner. Authorizes coverage to be subject to annual deductables, copayments, and coinsurance that are consistent those required for other coverage under the health benefit plan, and prohibits it from being subject to annual dollar limits.

Sec. 1371.004. PREAUTHORIZATION. Authorizes a health benefit plan to require prior authorization for a prosthetic or orthotic device in the same manner as is required for any other covered benefit.

Sec. 1371.005. MANAGED CARE PLAN. Authorizes a health benefit plan provider to require that benefits provided by a managed care plan under this chapter are covered only if the prosthetic or orthotic devices are provided by a vendor, and related services are rendered by a provider that is contracted or designated by the health benefit plan provider. Requires that coverage provided through in-network services be equal to that of out-of-network services if the provider provides both services.

SECTION 2. Makes application of this Act prospective to January 1, 2008.

SECTION 3. Effective date: September 1, 2007.