BILL ANALYSIS

H.B. 806
By: Gallego
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

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. 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.

H.B. 806 requires certain health benefit plans to provide coverage for prosthetic and orthotic devices and services 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

H.B. 806 amends the Insurance Code to require a health benefit plan to 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 applicable sections of the federal Social Security Act and other federal rules. The bill limits covered benefits 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. The bill requires coverage to be provided in a manner determined to be appropriate in consultation with the enrollee and, as applicable, the treating physician or podiatrist and prosthetist or orthotist; authorizes the coverage to be subject to annual deductibles, copayments, and coinsurance that are consistent with those required by the health benefit plan for other coverage; and prohibits coverage from being subject to annual dollar limits. The bill makes the repair and replacement of a prosthetic device or orthotic device a covered benefit unless the repair or replacement is due to misuse or loss by the enrollee. The bill authorizes covered benefits to 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. The provisions of this bill do not preclude a pharmacy from being reimbursed by a health benefit plan for the provision of orthotic services. The bill authorizes a health benefit plan to require prior authorization for a prosthetic device or an orthotic device in the same manner that the health benefit plan requires authorization for any other covered benefit. The bill authorizes a health benefit plan provider to require that, if coverage is provided through a managed care plan, the benefits for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices are covered benefits only if the 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. The bill requires that the health coverage for prosthetic devices or orthotic devices provided through out-of-network services be comparable to that provided through in-network

services, if the health benefit plan provider provides in-network and out-of-network services.

H.B. 806 applies the health benefit plan coverage requirements for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices to a health benefit plan, including a small employer health benefit plan or coverage provided by a health group cooperative under the Health Insurance Portability and Availability Act, 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, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document. The bill makes its provisions applicable to such a health benefit plan or coverage provided by a health group cooperative that is offered by an insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium company, a reciprocal exchange, a Lloyd's plan, a health maintenance organization, a certified multiple employer welfare arrangement, or an approved nonprofit health corporation certified by the Texas Medical Board. The bill makes its provisions applicable to health and accident coverage provided by a risk pool created under the Texas Political Subdivision Employees Uniform Group Benefits Act, a basic coverage plan under the Texas Employees Group Benefits Act, a basic plan under the Texas Public School Retired Employees Group Benefits Act, a primary care coverage plan under the Texas School Employees Uniform Group Health Coverage Act, and basic coverage under the State University Employees Uniform Insurance Benefits Act.

H.B. 806 defines "orthotic device" to mean a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve functions, or relieve symptoms of disease. The bill defines "prosthetic device" to mean an artificial device designed to replace, wholly or partly, an arm or leg. The bill defines "enrollee" to mean an individual entitled to coverage under a health benefit plan.

H.B. 806 makes its provisions applicable to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010.

EFFECTIVE DATE

September 1, 2009.