HB 579

Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

House Bill 579 (Delegate Mizeur, *et al.*)
Health and Government Operations Finance

Prosthetic Parity Act

This bill requires insurers, nonprofit health service plans, and health maintenance organizations (carriers) to provide coverage for prosthetic devices, components of prosthetic devices, and repair of prosthetic devices.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2009.

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2010. The review of rate filings can be handled within existing MIA resources. No impact on the State employee and retiree health insurance program (State plan) as all health benefit plans currently provided include coverage in compliance with the bill's requirements.

Local Effect: To the extent that the coverage mandated under the bill exceeds that currently provided by local governments in their fully insured health benefit plans, health insurance expenditures for local governments may increase.

Small Business Effect: None. The bill does not apply to the small group health insurance market.

Analysis

Bill Summary: "Prosthetic device" means an artificial device to replace, in whole or in part, a leg, arm, or eye. Prosthetic devices may not be subject to a higher copayment or

coinsurance requirement than those required for any primary care benefits. A carrier may not impose an annual or lifetime dollar maximum on coverage for prosthetic devices, separate from any maximum that applies in the aggregate to all covered benefits. A carrier may not establish requirements for medical necessity or appropriateness for prosthetic devices that are more restrictive than those under the Medicare Coverage Database.

Current Law: There are 43 mandated health insurance benefits that certain carriers must provide to their enrollees. Policies written by a nonprofit health service plan must provide benefits for prosthetic devices and orthopedic braces. Prosthetic devices are defined only as artificial limbs, and the extent of coverage required is not specified.

Under the Code of Maryland Regulations 31.11.06.03, the Comprehensive Standard Health Benefit Plan sold in the small group market must provide prosthetic devices such as leg, arm, back, or neck braces; artificial legs, arms, or eyes; and the training necessary to use these prostheses.

Every four years, the Maryland Health Care Commission (MHCC) examines the fiscal impact of mandated health insurance benefits. In January 2008, MHCC found that these benefits account for 15.4% of total premium costs for group health insurance and 18.6% of total premium costs for individual policies. The full cost of current mandated coverage for prosthetic devices and orthopedic braces is reported at 0% of premium costs. Approximately 50% of self-funded health benefit plans voluntarily provide coverage for habilitative services.

Background: Prosthetic devices enable amputees to perform everyday activities, return to work, exercise, and contribute to society. An estimated 14,000 nonelderly individuals live with limb loss in Maryland. The cost of prosthetic devices generally ranges from $2,000 to $40,000, with some advanced prostheses costing as much as $100,000.

A December 2008 MHCC analysis on coverage of prosthetic devices surveyed six Maryland carriers. All six carriers provide coverage for prosthetic devices, some with copayments, coinsurance, deductibles, and annual benefit maximums. Most carriers offer groups the option of purchasing policies with annual limits between $2,500 and $5,000. With such limits, some covered members may face large out-of-pocket costs to obtain prosthetic devices.

The MHCC analysis included the potential cost of a prosthetic device mandate *as proposed under SB 98 of 2008*, which required coverage that was at least equivalent to that provided under Medicare. The analysis estimated that the full cost of mandating such coverage would be 0.08% of the average group policy or $3.00 per member per year, with marginal costs of about half those figures.

Eleven states require coverage of prosthetic devices. Most of these states cap reimbursement at Medicare levels and either limit deductibles or copayments to Medicare levels ($100, 20%) or require them to be comparable to other benefits under the plan.

Additional Comments: To the extent that the coverage mandated under the bill exceeds that currently provided by carriers, health insurance premiums for fully insured health plans may increase.

Additional Information

Prior Introductions: None.

Cross File: SB 341 (Senator Pugh, *et al.*) - Finance.

Information Source(s): *Annual Mandated Health Insurance Services Evaluation,* Maryland Health Care Commission, December 31, 2008; *Study of Mandated Health Insurance Services: A Comparative Evaluation*, Maryland Health Care Commission, January 1, 2008; CareFirst BlueCross BlueShield; Department of Budget and Management; Maryland Health Insurance Plan; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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