SB 614

Department of Legislative Services

Maryland General Assembly
2024 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 614 (Senator Beidle, *et al.*)

Finance Health and Government Operations

Maryland Medical Assistance Program and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)

This bill expands the current mandated benefit for coverage of prosthetic devices to be coverage for prostheses and replacement for prostheses. Beginning January 1, 2025, Medicaid must provide coverage for prostheses, as specified. Each insurer, nonprofit health service plan, and health maintenance organization (collectively known as carriers) and Medicaid managed care organization (MCO) must submit a specified compliance report by June 30, 2030, which must be aggregated and reported to specified committees of the General Assembly by December 31, 2030. The Maryland Health Care Commission (MHCC) and the Maryland Department of Health (MDH) must review utilization of specified codes, evaluate the cost impact of requiring coverage for orthoses, and report to specified committees of the General Assembly by December 1, 2024. **The bill takes effect January 1, 2025, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Medicaid expenditures increase by an estimated $1.7 million (50% general funds, 50% federal funds) in FY 2025; federal fund revenues increase accordingly. Future years reflect annualization and enrollment growth. Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2025 only from the $125 rate and form filing fee; any additional workload for MIA can be handled with existing budgeted resources. No meaningful impact on the State Employee and Retiree Health and Welfare Benefits Program, as discussed below. **This bill increases the cost of an entitlement program beginning in FY 2025.**

($ in millions)	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029
SF Revenue	-	$0	$0	$0	$0
FF Revenue	$0.8	$1.7	$1.8	$1.8	$1.9
GF/FF Exp.	$1.7	$3.5	$3.6	$3.7	$3.8
Net Effect	($0.8)	($1.7)	($1.8)	($1.8)	($1.9)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: To the extent health insurance costs increase as a result of the bill, health care expenditures for local governments that purchase fully insured health benefit plans may increase. Revenues are not affected.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary:

Coverage of Prostheses

Definitions: The term "prosthetic device" is changed to "prosthesis" and expanded to include a custom-designed, -fabricated, -fitted, or -modified device to treat partial or total limb loss for purposes of restoring physiological function.

Medical Necessity: Covered benefits include prostheses determined by a treating health care provider to be medically necessary for completing activities of daily living, essential job-related activities, or performing physical activities to maximize the whole-body health and lower or upper limb function of the insured or enrollee.

Coverage Requirements: A carrier must provide – once annually – coverage for prostheses, components of prostheses, and repairs to prostheses, as well as replacements of prostheses and prosthesis components.

Limitations: Coverage for prostheses may not be subject to a higher copayment or coinsurance than for other similar medical and surgical benefits under the policy or contract.

Replacement of Prostheses or Prosthesis Components: Coverage for replacement of prostheses must be provided if an ordering health care provider determines that the provision of a replacement prosthesis (or a component) is necessary (1) because of a change in the physiological condition of the patient; (2) unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or component; or (3) unless necessitated by misuse, because the condition of the prosthesis or component requires repairs that cost more than 60% of the cost of replacing the prosthesis or component. A carrier may require an ordering health care provider to confirm that the prosthesis or component being replaced meets these requirements if the prosthesis or component is less than three years old.

Provider Network: A carrier that uses a provider panel for a policy or contract and the provision of benefits for prostheses must comply with existing requirements governing provider panels. Specifically, a carrier must (1) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay and (2) include standards that ensure access to providers, including essential community providers, that serve predominantly low-income and medically underserved individuals or include alternative standards for addressing the needs of low-income, medically underserved individuals.

Medicaid Coverage of Prostheses

Beginning January 1, 2025, Medicaid must provide coverage for prostheses in accordance with the same requirements applicable to carriers.

Uncodified language expresses the intent of the General Assembly that the bill may not be construed to require Medicaid MCOs to cover additional Healthcare Common Procedure Coding System (HCPCS) "L" codes for prosthetic procedures and devices beyond those that are covered by MCOs as of December 31, 2024.

Compliance Reporting Requirement

By June 30, 2030, each carrier and Medicaid MCO must report to MIA and MDH on its compliance with the bill for calendar 2025 through 2028. The report must be in a form jointly prescribed by MIA and MDH and include the number of claims and the total amount of claims paid in the State for coverage of prostheses. MIA and MDH must aggregate the data by calendar year in a joint report. By December 31, 2030, MIA and MDH must submit a joint report to the Senate Finance Committee and the House Health and Government Operations Committee.

Review of Healthcare Common Procedure Coding System "L" Codes

MHCC and MDH, in consultation with MIA, must review utilization of "L" codes and related codes within the All-Payer Claims Database (APCD) and evaluate the cost impact of requiring coverage for orthoses, including medically necessary activity-specific orthoses, by Medicaid and commercial health insurance plans. By December 1, 2024, MHCC and MDH must report the findings of the review to specified committees of the General Assembly.

Current Law: Under Maryland law, there are more than 50 mandated health insurance benefits that certain carriers must provide. Each health insurance contract delivered or issued in the State by a nonprofit health service plan must provide benefits for orthopedic braces. Carriers must provide coverage for prosthetic devices (an artificial device to

replace, in whole or in part, a leg, arm, or eye), components of prosthetic devices, and repair of prosthetic devices. 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.

The federal Patient Protection and Affordable Care Act requires nongrandfathered health plans to cover 10 essential health benefits (EHBs), which include rehabilitative and habilitative services and devices. Under § 31-116 of the Maryland Insurance Article, EHBs must be included in the State benchmark plan and, not withstanding any other benefits mandated by State law, must be the benefits required in (1) all individual health benefit plans and health benefit plans offered to small employers (except for grandfathered health plans) offered outside the Maryland Health Benefit Exchange (MHBE) and (2) all qualified health plans offered in MHBE.

State Fiscal Effect:

Medicaid Coverage of Prostheses

Current Coverage for Durable Medical Equipment: Medicaid does not apply copayment or lifetime limit requirements to durable medical equipment (DME). Medicaid's fee-for-service (FFS) participants have access to medically necessary DME. Medicaid contracts with a utilization control agent that is responsible for receiving and processing DME requests for FFS participants.

MCOs provide coverage for DME for HealthChoice participants and may require prior authorization. MDH advises that MCO coverage does not currently include 87 HCPCS "L" codes (codes used by providers to bill for orthotic and prosthetic procedures and devices) that are covered under FFS and Medicare.

Estimated Impact on Expenditures: Medicaid advises that expenditures increase due to the bill's "whole-body health" provision, which requires coverage of prostheses for "performing physical activities to maximize the whole-body health and lower or upper limb function." Thus, Medicaid expenditures increase by an estimated $1.7 million in fiscal 2025 (50% general funds, 50% federal funds), which accounts for implementation of the bill's Medicaid provisions effective January 1, 2025. This estimate reflects the cost of claims for whole-body health-related prostheses. The information and assumptions used in calculating the estimate are stated below:

- An average of 1,000 Medicaid participants have claims or encounters for DME with an associated limb loss diagnosis annually.
- An estimated 30% of these individuals (300) will seek whole-body health-related prostheses under the bill.
- The average cost of a "whole-body health" prosthesis is $11,250.
- Total costs for whole-body health-related DME claims are $3.4 million on an annualized basis ($1.7 million in fiscal 2025).
- Future years reflect 3% annual growth in the Medicaid population.

Review of Healthcare Common Procedure Coding System "L" Codes

The bill requires MHCC and MDH, in consultation with MIA, to review utilization of "L" codes and related codes within the APCD and evaluate the cost of requiring coverage for orthoses, including medically necessary activity-specific orthoses, by Medicaid and commercial health insurance plans. MHCC and MDH must report their findings to specified committees of the General Assembly by December 1, 2024. MHCC and MDH can complete this review and submit the required report using existing budgeted resources.

State Employee and Retiree Health and Welfare Benefits Program

The Department of Budget and Management advises that the State Employee and Retiree Health and Welfare Benefits Program provides coverage for prostheses. Thus, the bill would have a negligible impact on the program.

Small Business Effect: Small business health care providers that provide prostheses and related services may receive additional business under the bill.

Additional Comments: The bill includes a review and related reporting requirement, which must be completed by December 1, 2024, which is one month *before* the bill's effective date of January 1, 2025.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced in the last three years.

Designated Cross File: HB 865 (Delegate Martinez, *et al.*) - Health and Government Operations.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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