SB100

195875-3

By Senator Beasley

RFD: Healthcare

First Read: 19-MAR-19

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SYNOPSIS: This bill would require a health benefit plan to include coverage for prosthetic and orthotic devices under certain conditions.

A BILL

TO BE ENTITLED

AN ACT

To require health benefit plans to include certain coverage for prosthetic and orthotic devices under certain conditions; and to amend Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, relating to health care service plans and health maintenance organizations to further provide for the coverage.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. (a) As used in this section, the following words have the following meanings:

(1) HEALTH BENEFIT PLAN. Any group insurance plan, policy, or contract for health care services that covers hospital, medical, or surgical expenses, health maintenance

organizations, preferred provider organizations, medical service organizations, physician-hospital organizations, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes group health care services to patients, insureds, or beneficiaries in this state. For the purposes of this section, a health benefit plan located or domiciled outside of the State of Alabama is deemed to be subject to this section if the plan, policy, or contract is issued or delivered in the State of Alabama. The term includes, but is not limited to, entities created pursuant to Article 6, Chapter 20, Title 10A. On and after December 31, 2020, the term includes health insurance plans administered or offered by the State Employees Insurance Board and the Public Education Employees Health Insurance Plan. The term does not include the Alabama Health Insurance Plan or the Alabama Small Employer Allocation Program provided in Chapter 52 of this title. The term also includes the terms health insurance policy and health insurance plan. The term does not include non-grandfathered plans in the individual and small group markets that were required to provide essential health benefits under the Patient Protection and Affordable Care Act, or accident-only, specified disease, individual hospital indemnity, credit, dental-only, Medicare-supplement, long-term care, or disability income insurance, other limited benefit health insurance policies, coverage issued as a supplemental to

liability insurance, workers' compensation or similar insurance, or automobile medical-payment insurance.

(2) ORTHOTIC DEVICE. A custom orthosis as defined in Section 34-25A-3, Code of Alabama 1975.

(3) PROSTHETIC DEVICE. A custom prothesis as defined in Section 34-25A-3, Code of Alabama 1975.

(b) Any health benefit plan providing coverage for hospital, medical, or surgical expenses shall provide coverage for benefits for custom prosthetic and orthotic devices that are at least equivalent to that provided by the federal Medicare program and no less favorable than the terms and conditions for the medical and surgical benefits in the policy. The health benefit plan shall cover the most appropriate prosthetic and orthotic devices that are determined to be medically necessary by the treating physician to restore functionality to optimal levels. The coverage required shall include all services and supplies necessary for the effective use of a custom prosthetic or othotic device, including formulating its design, fabrication, material, and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device and all materials and components necessary to use the device.

(c) The reimbursement rate for prosthetic and orthotic devices in a health benefit plan shall be at least equivalent to that provided by the federal Medicare program and no more restrictive than other benefits in the plan and

shall be comparable to coverage of restorative internal devices. The coverage required shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(d) Prosthetic and orthotic device benefits may not be subject to separate financial requirements that are applicable only with respect to the benefits. A health benefit plan may impose copayment or coinsurance amounts on prosthetic and orthotic benefits, except any financial requirements applicable to the benefits may not be more restrictive than the financial requirements applicable to the plan's medical and surgical benefits, including those for internal devices.

(e) A health benefit plan may limit the benefits for or alter the financial requirements for out-of-network coverage of prosthetic and orthotic devices, except the restrictions and requirements applicable to the benefits may not be more restrictive than the financial requirements applicable to the out-of-network coverage for the plan's medical and surgical benefits.

(f) The requirements of this section shall apply separately with respect to benefits provided under the plan on an in-network basis and benefits provided under the plan on an out-of-network basis.

(g) A health benefit plan may not impose any annual or lifetime dollar maximum on coverage for prosthetic and orthotic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the policy.

(h) If coverage for prosthetic and orthotic devices is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct prosthetic and orthotic device providers in this state in the managed care plan's provider network.

Section 2. Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, are amended to read as follows:

"§10A-20-6.16.

"(a) No statute of this state applying to insurance companies shall be applicable to any corporation organized under this article and amendments thereto or to any contract made by the corporation; except the corporation shall be subject to the following:

"(1) The provisions regarding annual premium tax to be paid by insurers on insurance premiums.

"(2) Chapter 55 of Title 27, regarding the prohibition of unfair discriminatory acts by insurers on the basis of an applicant's or insured's abuse status.

"(3) The Medicare Supplement Minimum Standards set forth in Article 2 of Chapter 19 of Title 27, and Long-Term

Care Insurance Policy Minimum Standards set forth in Article 3 of Chapter 19 of Title 27.

"(4) Section 27-1-17, requiring insurers and health plans to pay health care providers in a timely manner.

"(5) Chapter 56 of Title 27, regarding the Access to Eye Care Act.

"(6) Rules promulgated by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

"(7) Chapter 54 of Title 27.

"(8) Chapter 57 of Title 27, requiring coverage to be offered for the payment of colorectal cancer examinations for covered persons who are 50 years of age or older, or for covered persons who are less than 50 years of age and at high risk for colorectal cancer according to current American Cancer Society colorectal cancer screening guidelines.

"(9) Chapter 58 of Title 27, requiring that policies and contracts including coverage for prostate cancer early detection be offered, together with identification of associated costs.

"(10) Chapter 59 of Title 27, requiring that policies and contracts including coverage for chiropractic be offered, together with identification of associated costs.

"(11) Chapter 54A of Title 27, requiring that policies and contracts to offer coverage for certain treatment for Autism Spectrum Disorder under certain conditions.

"(12) Chapter 12A of Title 27.

"(13) Chapter 2B of Title 27.

"(14) Chapter 29 of Title 27.

"(15) Section 1 of the act adding this subdivision requiring coverage for prosthetic and orthotic devices.

"(b) The provisions in subsection (a) that require specific types of coverage to be offered or provided shall not apply when the corporation is administering a self-funded benefit plan or similar plan, fund, or program that it does not insure.

"§27-21A-23.

"(a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of health care service plan laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or health care service plan licensed and regulated pursuant to the insurance law or the health care service plan laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

"(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

"(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing

medicine and shall be exempt from the provisions of Section 34-24-310, et seq., relating to the practice of medicine.

"(d) No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance, or malpractice in connection with the furnishing of such services and supplies.

"(e) Nothing in this chapter shall be construed in any way to repeal or conflict with any provision of the certificate of need law.

"(f) Notwithstanding the provisions of subsection (a), a health maintenance organization shall be subject to all of the following:

"(1) Section 27-1-17.

"(2) Chapter 56, regarding the Access to Eye Care Act.

"(3) Chapter 54, regarding mental illness coverage.

"(4) Chapter 57, requiring coverage to be offered for the payment of colorectal cancer examinations for covered persons who are 50 years of age or older, or for covered persons who are less than 50 years of age and at high risk for colorectal cancer according to current American Cancer Society colorectal cancer screening guidelines.

"(5) Chapter 58, requiring that policies and contracts including coverage for prostate cancer early

detection be offered, together with identification of associated costs.

"(6) Chapter 59, requiring that policies and contracts including coverage for chiropractic be offered, together with identification of associated costs.

"(7) Rules promulgated by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

"(8) Chapter 12A.

"(9) Chapter 54A, requiring policies and contracts to cover certain treatment for Autism Spectrum Disorder under certain conditions.

"(10) Chapter 2B, regarding risk-based capital.

"(11) Chapter 29, regarding insurance holding company systems.

"(12) Section 1 of the act adding this subdivision requiring coverage for prosthetic and orthotic devices."

Section 3. This act shall become effective on October 1, 2019.