HB 616 -- Health Insurance Coverage for Prosthetic Devices

Sponsor: Cooper

Beginning January 1, 2010, this bill requires all health insurance carriers or health benefit plans which are issued, delivered, continued, or renewed to provide coverage for certain prosthetic devices and related services and supplies that meet minimum standards as provided under the federal Medicare Program. "Prosthetic device" is defined as an artificial limb, device, or appliance designed to replace in whole or in part an arm, leg, or eye.

A health insurance carrier:

(1) May require an insured to obtain prior authorization for any prosthetic device;

(2) May impose co-payments and co-insurance requirements in accordance with Part B of the federal Medicare Fee-for-Service Program; and

(3) Must reimburse an insured for the devices at no less than the fee schedule amount under the federal Medicare reimbursement schedule.

The coverage benefits will:

(1) Be limited to the most appropriate devices that adequately meet the medical needs of the insured to perform activities of daily living and essential job-related activities as determined by his or her physician;

(2) Include repair services and replacement of prosthetics needed to restore or maintain the daily living or essential job-related activities; and

(3) Not impose any annual or lifetime benefit maximum for prosthetic devices.

Certain other supplemental insurance polices are not subject to the prosthetic devices coverage requirements.