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111TH CONGRESS
1ST SESSION

H. R. 2575

To provide parity under group health plans and group health insurance coverage in the provision of benefits for prosthetic devices and orthotics devices, components and benefits for other medical and surgical services.

IN THE HOUSE OF REPRESENTATIVES

MAY 21, 2009

Mr. ANDREWS (for himself, Mr. GEORGE MILLER of California, Mr. LINCOLN DIAZ-BALART of Florida, Mr. PLATTS, Mr. SESTAK, and Mr. AL GREEN of Texas) introduced the following bill; which was referred to the Committee on Education and Labor

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A BILL

To provide parity under group health plans and group health insurance coverage in the provision of benefits for prosthetic devices and orthotics devices, components and benefits for other medical and surgical services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Prosthetic and Custom Orthotic Parity Act of 2009''.

SEC. 2. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds the following:

(1) There are more than 1,800,000 people in the United States living with limb loss.

(2) Every year, there are more than 130,000 people in the United States who undergo amputation.

(3) In addition, United States military personnel serving in Iraq and Afghanistan and around the world have sustained traumatic injuries resulting in amputation.

(4) The number of amputations in the United States is projected to increase in the years ahead due to rising incidence of diabetes and other chronic illness.

(5) Those suffering from limb loss can and want to regain their lives as productive members of society.

(6) Prosthetic devices enable amputees to continue working and living productive lives.

(7) Insurance companies have begun to limit reimbursement of prosthetic equipment costs at unrealistic levels or not at all and often restrict coverage over a person's lifetime, which shifts costs onto the Medicare and Medicaid programs.

(8) Eleven States have addressed this problem and have enacted prosthetic parity legislation.

(9) Prosthetic parity legislation has been introduced and is being actively considered in 30 States.

(10) The States in which prosthetic parity laws have been enacted have found there to be minimal or no increases in insurance premiums and have reduced Medicare and Medicaid costs.

(11) Prosthetic parity legislation will not add to the size of government or to the costs associated with the Medicare or Medicaid programs.

(12) If coverage for prosthetic devices and components are offered by a group health insurance policy, then providing such coverage of prosthetic devices on par with other medical and surgical benefits will not increase the incidence of amputations or the number of individuals for which a prosthetic device would be medically necessary and appropriate.

(13) In States where prosthetic parity legislation has been enacted, amputees are able to return to a productive life, State funds have been saved, and the health insurance industry has continued to prosper.

(14) Prosthetic services allow people to return more quickly to their preexisting work.

(15) Spina bifida occurs in 7 out of every 10,000 live births in the United States.

(16) For children with spina bifida, access to a custom orthotic device impacts both their short and long term mobility, their muscle strength, and overall quality of life. As they mature, the orthotic device allows them to maintain their maximum level of functionality. This has a profound impact on their ability to become and remain independent and productive members of the community.

(17) Cerebral palsy is one of the most common congenital (existing before birth or at birth) disorders of childhood. About 10,000 babies per year in the United States will develop cerebral palsy.

(18) The purpose of a custom orthotic device for people with cerebral palsy is to protect, such as stabilizing a fracture during healing; to prevent deformity, such as stretching braces worn while the person sleeps, to help prevent muscle contractures; and to improve function. This can help kids with cerebral palsy achieve maximum potential in growth and development.

(19) If coverage for prosthetic and custom orthotic devices and related services is offered to individuals by a group health insurance policy, then providing such coverage of prosthetic and orthotic devices on par with other medical and surgical bene-

fits will not increase the incidence of amputations or the number of individuals for which a prosthetic or custom orthotic device would be medically necessary and appropriate.

(b) PURPOSE.—The purpose of this Act is to require that each group health plan that provides both coverage for prosthetic devices and components and medical and surgical benefits, provide such coverage under terms and conditions that are no less favorable than the terms and conditions under which such benefits are provided under such plan.

SEC. 3. PROSTHETICS AND CUSTOM ORTHOTIC DEVICE PARITY UNDER ERISA.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 713 (29 U.S.C. 1185b) the following new section:

"SEC. 715. PROSTHETICS AND CUSTOM ORTHOTIC DEVICE PARITY.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and benefits for prosthetic devices and components and orthotic devices (as defined under subsection (d)(1))—

''(1) such benefits for prosthetic devices and components and custom orthotic devices and related services under the plan (or coverage) shall be provided under terms and conditions that are no less favorable than the terms and conditions applicable to substantially all medical and surgical benefits provided under the plan (or coverage);

''(2) such benefits for prosthetic devices and components and custom orthotic devices and related services under the plan (or coverage) may not be subject to separate financial requirements (as defined in subsection (d)(2)) that are applicable only with respect to such benefits, and any financial requirements applicable to such benefits may be no more restrictive than the financial requirements applicable to substantially all medical and surgical benefits provided under the plan (or coverage); and

''(3) any treatment limitations (as defined in subsection (d)(3)) applicable to such benefits for prosthetic devices and components and custom orthotic devices and related services under the plan (or coverage) may not be more restrictive than the treatment limitations applicable to substantially all medical and surgical benefits provided under the plan (or coverage).

''(b) IN-NETWORK AND OUT-OF-NETWORK STANDARDS.—

''(1) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and benefits for prosthetic devices and components and custom orthotic devices and related services, and that provides both in-network benefits for prosthetic devices and components and out-of-network benefits for prosthetic devices and components, the requirements of this section shall apply separately with respect to benefits provided under the plan (or coverage) on an in-network basis and benefits provided under the plan (or coverage) on an out-of-network basis.

''(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or health insurance coverage offered in connection with such a plan) eliminate an out-of-network provider option from such plan (or coverage) pursuant to the terms of the plan (or coverage).

''(c) ADDITIONAL REQUIREMENTS.—

''(1) PRIOR AUTHORIZATION.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that requires,

as a condition of coverage or payment for prosthetic devices and custom orthotic devices and related services under the plan (or coverage), prior authorization, such prior authorization must be required in the same manner as prior authorization is required by the plan (or coverage) as a condition of coverage or payment for all similar benefits provided under the plan (or coverage).

''(2) LIMITATION ON MANDATED BENEFITS.—Required benefits for prosthetic devices and custom orthotic devices and related services under this section are limited to the most appropriate model that adequately meets the medical requirements of the patient, as determined by the treating physician of the patient.

''(3) COVERAGE FOR REPAIR OR REPLACEMENT.—Benefits for prosthetic devices and custom orthotic devices and related services required under this section shall include coverage for repair or replacement of prosthetic devices and components, if the repair or replacement is determined appropriate by the treating physician of the patient involved.

''(4) ANNUAL OR LIFETIME DOLLAR LIMITATIONS.—A group health plan (or health insurance coverage offered in connection with such a plan)

may not impose any annual or lifetime dollar limitation on benefits for prosthetic devices and custom orthotic devices and related services unless such limitation applies in the aggregate to all medical and surgical benefits provided under the plan (or coverage) and benefits for prosthetic devices and components.

''(d) DEFINITIONS.—For the purposes of this section:

''(1) PROSTHETIC DEVICES AND COMPONENTS.—The term 'prosthetic devices and components' means such devices and components which may be used to replace, in whole or in part, an arm or leg, as well as the services required to do so, and includes external breast prostheses incident to mastectomy resulting from breast cancer.

''(2) CUSTOM ORTHOTIC DEVICES AND RELATED SERVICES.—The term 'custom orthotic devices and related services' means the following:

''(A) Custom-fabricated orthotics and related services, which include custom-fabricated devices that are individually made for a specific patient, as well as all services and supplies medically necessary for the effective use of the orthotic device, including formulating its design, fabrication, material and component selection,

measurements, fittings, and static and dynamic alignments, and instructing the patient in the use of the device. No other patient would be able to use this item. A custom fabricated item is a device which is fabricated based on clinically derived and rectified castings, tracings, measurements, and/or other images (such as x-rays) of the body part. The fabrication may involve using calculations, templates and components. This process requires the use of basic materials including, but not limited to plastic, metal, leather or cloth in the form of uncut or unshaped sheets, bars, or other basic forms and involves substantial work such as vacuum forming, cutting, bending, molding, sewing, drilling and finishing prior to fitting on the patient. Custom-fabricated devices may be furnished only by an appropriately credentialed (certified or licensed) practitioner or accredited supplier in orthotics and/or prosthetics. These devices and services are represented by the existing set of L-codes describing this care currently listed in Centers for Medicare and Medicaid Services Transmittal 656.

"(B) Custom-fitted high orthotics and related services, which include prefabricated devices that are manufactured with no specific patient in mind, but that are appropriately sized, adapted, modified, and configured (with the required tools and equipment) to a specific patient in accordance with a prescription, and which no other patient would be able to use, as well as all services and supplies medically necessary for the effective use of the orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, and static and dynamic alignments, and instructing the patient in the use of the device. Custom-fitted high devices may be furnished only by an appropriately credentialed (certified or licensed) practitioner or accredited supplier in orthotics and/or prosthetics. These devices and services are represented by the existing set of L-codes describing this care currently listed in Centers for Medicare and Medicaid Services Transmittal 656.

"(3) FINANCIAL REQUIREMENTS.—The term 'financial requirements' includes deductibles, coin-

surance, co-payments, other cost sharing, and limitations on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan or health insurance coverage and also includes the application of annual and lifetime limits.

''(4) TREATMENT LIMITATIONS.—The term 'treatment limitations' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 715. Prosthetics and custom orthotic device parity.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans (and health insurance coverage offered in connection with group health plans) for plan years beginning on or after the date of the enactment of this Act.

SEC. 4. FEDERAL ADMINISTRATIVE RESPONSIBILITIES.

(a) ASSISTANCE TO PLAN PARTICIPANTS AND BENEFICIARIES.—The Secretary of Labor shall provide for assistance to participants and beneficiaries under such plans with any questions or problems regarding compliance with the requirements of this section.

(b) AUDITS.—The Secretary of Labor shall provide for the conduct of random audits of group health plans (and health insurance coverage offered in connection with such plans) to ensure that such plans are in compliance with section 715 of the Employee Retirement Income Security Act of 1974, as added by section 3.

(c) GAO STUDY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that evaluates the effect of the implementation of the amendments made by this Act on the cost of health insurance coverage, on access to health insurance coverage (including the availability of in-network providers), on the quality of health care, on benefits and coverage for prosthetic devices and components, on any additional cost or savings to group health plans, on State prosthetic devices and components benefit mandate laws, on the business community and the Federal Government, and on other issues as determined appropriate by the Comptroller General.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the appropriate committees of Congress a re-

port containing the results of the study conducted under paragraph (1).

(d) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Labor shall promulgate final regulations to carry out this Act and the amendments made by this Act.

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