



**PA 18-69—SB 376**

*Insurance and Real Estate Committee  
Appropriations Committee*

**AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PROSTHETIC DEVICES**

**SUMMARY:** This act requires certain health insurance policies to cover prosthetic devices, and medically necessary repairs and replacements to them, subject to specified conditions. It defines a “prosthetic device” as an artificial device to replace all or part of an arm or leg, including one with a microprocessor if the patient’s health care provider determines it is medically necessary. It excludes a device that is designed exclusively for athletic purposes.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2019

**PROSTHETIC DEVICES**

*Coverage Required*

Under the act, insurance coverage for a prosthetic device must be at least equivalent to the coverage Medicare provides for such devices. (Medicare generally covers 80% of the cost of prostheses, after the patient pays his or her annual deductible.) The act allows a policy to limit coverage to a device that the patient’s health care provider determines is most appropriate to meet his or her medical needs.

The act also requires policies to cover repairs or replacements of prosthetic devices that the patient’s health care provider determines are medically necessary, but not those needed because of misuse or loss.

*Out-of-Pocket Expenses*

The act prohibits a policy from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on most other policy benefits. However, the prohibition concerning deductibles does not apply to high deductible plans designed to be compatible with federally qualified health savings accounts.

## OLR PUBLIC ACT SUMMARY

### *Durable Medical Equipment*

The act prohibits a policy from considering a prosthetic device as durable medical equipment (DME). Thus, the amount covered will not count toward a DME maximum under the policy.

### *Prior Authorization*

The act allows a policy to require prior authorization for prosthetic devices, but only in the same manner and to the same extent as it requires it for other policy benefits.

## BACKGROUND

### *Related Federal Law*

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148, § 1311(d)(3)), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required essential health benefits, provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. The state must pay the insurance carrier or enrollee to defray the cost of any new benefits it mandates after that date.