SENATE BILL 614

J5, J1 4lr1551
CF 4lr3211

By: **Senators Beidle and Elfreth**
Introduced and read first time: January 26, 2024
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Maryland Medical Assistance Program and Health Insurance – Coverage for Orthoses and Prostheses

FOR the purpose of requiring the Maryland Medical Assistance Program and certain insurers, nonprofit health service plans, and health maintenance organizations to provide certain coverage related to orthoses and prostheses; requiring certain insurers, nonprofit health service plans, and health maintenance organizations to render utilization review determinations relating to the coverage in a nondiscriminatory manner; establishing certain provider network and reimbursement requirements relating to the covered benefits; and generally relating to coverage and reimbursement for orthoses and prostheses.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–103(a)(1)
Annotated Code of Maryland
(2023 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–103(a)(2)(xxii) and (xxiii)
Annotated Code of Maryland
(2023 Replacement Volume)

BY adding to
Article – Health – General
Section 15–103(a)(2)(xxiv)
Annotated Code of Maryland
(2023 Replacement Volume)

BY repealing and reenacting, with amendments,

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

Article – Insurance
Section 15–820 and 15–844
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

15–103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(xxii) Beginning on January 1, 2024, shall provide gender–affirming treatment in accordance with § 15–151 of this subtitle; **[**and**]**

(xxiii) Beginning on July 1, 2025, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for biomarker testing in accordance with § 15–859 of the Insurance Article**; AND**

(XXIV) BEGINNING ON JANUARY 1, 2025, SHALL PROVIDE COVERAGE FOR ORTHOSES AND PROSTHESES IN ACCORDANCE WITH §§ 15–820 AND 15–844 OF THE INSURANCE ARTICLE.

Article – Insurance

15–820.

(a) In this section, **[**"orthopedic brace" means a rigid or semi–rigid device that is used to:

(1) support a weak or deformed body member; or

(2) restrict or eliminate motion in a diseased or injured part of the body.**]** **"ORTHOSIS" MEANS A CUSTOM DESIGNED, CUSTOM FABRICATED, CUSTOM FITTED, PREFABRICATED, OR MODIFIED DEVICE TO TREAT A NEUROMUSCULAR OR MUSCULOSKELETAL DISORDER OR ACQUIRED CONDITION.**

(B) THIS SECTION APPLIES TO:

(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS

ON AN EXPENSE–INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

[(b)**] (C) [**Each health insurance contract that is delivered or issued for delivery in the State by a nonprofit health service plan and that provides hospital benefits**] AN ENTITY SUBJECT TO THIS SECTION** shall provide **[**benefits**] COVERAGE** for **[**orthopedic braces**] ORTHOSES AND, SUBJECT TO SUBSECTION (D) OF THIS SECTION, REPLACEMENTS FOR ORTHOSES**.

(D) (1) AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR REPLACEMENTS OF ORTHOSES WITHOUT REGARD TO CONTINUOUS USE OR USEFUL LIFETIME RESTRICTIONS IF AN ORDERING HEALTH CARE PROVIDER DETERMINES THAT THE PROVISION OF A REPLACEMENT ORTHOSIS OR A REPLACEMENT OF A COMPONENT OF THE ORTHOSIS IS NECESSARY:

(I) BECAUSE OF A CHANGE IN THE PHYSIOLOGICAL CONDITION OF THE PATIENT;

(II) BECAUSE OF AN IRREPARABLE CHANGE IN THE CONDITION OF THE ORTHOSIS OR A COMPONENT OF THE ORTHOSIS; OR

(III) BECAUSE THE CONDITION OF THE ORTHOSIS OR A COMPONENT OF THE ORTHOSIS REQUIRES REPAIRS AND THE COST OF THE REPAIRS WOULD BE MORE THAN 60% OF THE COST OF REPLACING THE ORTHOSIS OR THE COMPONENT OF THE ORTHOSIS.

(2) AN ENTITY SUBJECT TO THIS SECTION MAY REQUIRE AN ORDERING HEALTH CARE PROVIDER TO CONFIRM THAT THE ORTHOSIS OR COMPONENT OF THE ORTHOSIS BEING REPLACED MEETS THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION IF THE ORTHOSIS OR COMPONENT IS LESS THAN 3 YEARS OLD.

(E) AN ENTITY SUBJECT TO THIS SECTION SHALL CONSIDER THE COVERED BENEFITS UNDER THIS SECTION HABILITATIVE OR REHABILITATIVE BENEFITS FOR PURPOSES OF ANY FEDERAL OR STATE REQUIREMENT FOR COVERAGE OF ESSENTIAL HEALTH BENEFITS.

(F) THE COVERED BENEFITS UNDER THIS SECTION MAY NOT BE SUBJECT TO:

(1) SEPARATE FINANCIAL REQUIREMENTS THAT ARE APPLICABLE ONLY WITH RESPECT TO THAT COVERAGE; OR

(2) A HIGHER COPAYMENT OR COINSURANCE REQUIREMENT THAN THE COPAYMENT OR COINSURANCE FOR BENEFITS COVERED UNDER THE POLICY OR CONTRACT OF THE INSURED OR ENROLLEE THAT RELATE TO PRIMARY CARE OR INPATIENT PHYSICIAN OR SURGICAL SERVICES.

(G) AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE AN ANNUAL OR LIFETIME DOLLAR MAXIMUM ON COVERAGE REQUIRED UNDER THIS SECTION SEPARATE FROM ANY ANNUAL OR LIFETIME DOLLAR MAXIMUM THAT APPLIES IN THE AGGREGATE TO ALL COVERED BENEFITS UNDER THE POLICY OR CONTRACT OF THE INSURED OR ENROLLEE.

(H) (1) AN ENTITY SUBJECT TO THIS SECTION MAY NOT ESTABLISH REQUIREMENTS FOR MEDICAL NECESSITY OR APPROPRIATENESS FOR THE COVERAGE REQUIRED UNDER THIS SECTION THAT ARE MORE RESTRICTIVE THAN THE INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY ESTABLISHED UNDER THE MEDICARE COVERAGE DATABASE.

(2) THE COVERED BENEFITS UNDER THIS SECTION INCLUDE ORTHOSES IF THE TREATING PHYSICIAN DETERMINES THAT THE ORTHOSIS IS MEDICALLY NECESSARY FOR:

(I) COMPLETING ACTIVITIES OF DAILY LIVING;

(II) ESSENTIAL JOB–RELATED ACTIVITIES; OR

(III) PERFORMING PHYSICAL ACTIVITIES, INCLUDING RUNNING, BIKING, SWIMMING, STRENGTH TRAINING, AND OTHER ACTIVITIES TO MAXIMIZE THE WHOLE–BODY HEALTH AND LOWER OR UPPER LIMB FUNCTION OF THE INSURED OR ENROLLEE.

(I) AN ENTITY SUBJECT TO THIS SECTION SHALL RENDER UTILIZATION REVIEW DETERMINATIONS IN A NONDISCRIMINATORY MANNER AND MAY NOT DENY COVERAGE FOR BENEFITS REQUIRED UNDER THIS SECTION SOLELY ON THE BASIS OF AN INSURED'S OR ENROLLEE'S ACTUAL OR PERCEIVED DISABILITY.

(J) AN ENTITY SUBJECT TO THIS SECTION MAY NOT DENY BENEFITS REQUIRED UNDER THIS SECTION FOR AN INDIVIDUAL WITH LIMB LOSS OR ABSENCE THAT WOULD OTHERWISE BE COVERED FOR A NONDISABLED INDIVIDUAL SEEKING MEDICAL OR SURGICAL INTERVENTION TO RESTORE OR MAINTAIN THE ABILITY TO PERFORM THE SAME PHYSICAL ACTIVITY.

(K) AN ENTITY SUBJECT TO THIS SECTION SHALL INCLUDE LANGUAGE DESCRIBING THE INSURED'S OR ENROLLEE'S RIGHTS UNDER SUBSECTIONS (I) AND (J) OF THIS SECTION IN ITS EVIDENCE OF COVERAGE AND ANY BENEFIT DENIAL LETTER.

(L) (1) AN ENTITY SUBJECT TO THIS SECTION SHALL ENSURE ACCESS TO AT LEAST TWO DISTINCT ORTHOPEDIC PROVIDERS IN THE ENTITY'S PROVIDER NETWORK IN THE STATE FOR ORTHOSES, ORTHOSIS TECHNOLOGY, AND MEDICALLY NECESSARY CLINICAL CARE FOR ORTHOSES.

(2) (I) IN THE EVENT THAT THE BENEFITS REQUIRED UNDER THIS SECTION ARE NOT AVAILABLE FROM AN IN–NETWORK PROVIDER, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE PROCESSES TO REFER AN INSURED OR ENROLLEE TO AN OUT–OF–NETWORK PROVIDER.

(II) 1. AN ENTITY SUBJECT TO THIS SECTION SHALL REIMBURSE AN OUT–OF–NETWORK PROVIDER AT A MUTUALLY AGREED ON RATE AFTER SUBTRACTING ANY COST–SHARING REQUIREMENTS OF AN INSURED OR ENROLLEE.

2. COST–SHARING REQUIREMENTS OF AN INSURED OR ENROLLEE UNDER SUBSUBPARAGRAPH 1 OF THIS SUBPARAGRAPH SHALL BE DETERMINED AS IF THE BENEFITS WERE PROVIDED BY AN IN–NETWORK PROVIDER.

15–844.

(a) In this section, **[**"prosthetic device" means an artificial device to replace, in whole or in part, a leg, an arm, or an eye**] "PROSTHESIS" MEANS A CUSTOM DESIGNED, FABRICATED, FITTED, OR MODIFIED DEVICE TO TREAT PARTIAL OR TOTAL LIMB LOSS FOR PURPOSES OF RESTORING PHYSIOLOGICAL FUNCTION OR COSMESIS**.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for:

(1) **[**prosthetic devices**] PROSTHESES**;

(2) components of **[**prosthetic devices**]** **PROSTHESES**; **[**and**]**

(3) repairs to **[**prosthetic devices**]** **PROSTHESES; AND**

(4) SUBJECT TO SUBSECTION (D) OF THIS SECTION, REPLACEMENTS OF PROSTHESES OR PROSTHESIS COMPONENTS.

(D) (1) AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR REPLACEMENTS OF PROSTHESES WITHOUT REGARD TO CONTINUOUS USE OR USEFUL LIFETIME RESTRICTIONS IF AN ORDERING HEALTH CARE PROVIDER DETERMINES THAT THE PROVISION OF A REPLACEMENT PROSTHESIS OR A COMPONENT OF THE PROSTHESIS IS NECESSARY:

(I) BECAUSE OF A CHANGE IN THE PHYSIOLOGICAL CONDITION OF THE PATIENT;

(II) BECAUSE OF AN IRREPARABLE CHANGE IN THE CONDITION OF THE PROSTHESIS OR A COMPONENT OF THE PROSTHESIS; OR

(III) BECAUSE THE CONDITION OF THE PROSTHESIS OR THE COMPONENT OF THE PROSTHESIS REQUIRES REPAIRS AND THE COST OF THE REPAIRS WOULD BE MORE THAN 60% OF THE COST OF REPLACING THE PROSTHESIS OR THE COMPONENT OF THE PROSTHESIS.

(2) AN ENTITY SUBJECT TO THIS SECTION MAY REQUIRE AN ORDERING HEALTH CARE PROVIDER TO CONFIRM THAT THE PROSTHESIS OR COMPONENT OF THE PROSTHESIS BEING REPLACED MEETS THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION IF THE PROSTHESIS OR COMPONENT IS LESS THAN 3 YEARS OLD.

(E) AN ENTITY SUBJECT TO THIS SECTION SHALL CONSIDER THE COVERED BENEFITS UNDER THIS SECTION HABILITATIVE OR REHABILITATIVE BENEFITS FOR PURPOSES OF ANY FEDERAL OR STATE REQUIREMENT FOR COVERAGE OF ESSENTIAL HEALTH BENEFITS.

[(d)**]** **(F)** The covered benefits under this section may not be subject to**:**

(1) SEPARATE FINANCIAL REQUIREMENTS THAT ARE APPLICABLE ONLY WITH RESPECT TO THAT COVERAGE; OR

(2) a higher copayment or coinsurance requirement than the copayment or coinsurance for **[**primary care**]** benefits covered under the policy or contract of the insured

or enrollee **THAT RELATE TO PRIMARY CARE OR INPATIENT PHYSICIAN OR SURGICAL SERVICES**.

[(e)**] (G)** An entity subject to this section may not impose an annual or lifetime dollar maximum on coverage required under this section separate from any annual or lifetime dollar maximum that applies in the aggregate to all covered benefits under the policy or contract of the insured or enrollee.

[(f)**] (H) (1)** An entity subject to this section may not establish requirements for medical necessity or appropriateness for the coverage required under this section that are more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

(2) THE COVERED BENEFITS UNDER THIS SECTION INCLUDE PROSTHESES IF THE TREATING PHYSICIAN DETERMINES THAT THE PROSTHESIS IS MEDICALLY NECESSARY FOR:

(I) COMPLETING ACTIVITIES OF DAILY LIVING;

(II) ESSENTIAL JOB–RELATED ACTIVITIES; OR

(III) PERFORMING PHYSICAL ACTIVITIES, INCLUDING RUNNING, BIKING, SWIMMING, STRENGTH TRAINING, AND OTHER ACTIVITIES TO MAXIMIZE THE WHOLE–BODY HEALTH AND LOWER OR UPPER LIMB FUNCTION OF THE INSURED OR ENROLLEE.

(I) AN ENTITY SUBJECT TO THIS SECTION SHALL RENDER UTILIZATION REVIEW DETERMINATIONS IN A NONDISCRIMINATORY MANNER AND MAY NOT DENY COVERAGE FOR BENEFITS REQUIRED UNDER THIS SECTION SOLELY ON THE BASIS OF AN INSURED'S OR ENROLLEE'S ACTUAL OR PERCEIVED DISABILITY.

(J) AN ENTITY SUBJECT TO THIS SECTION MAY NOT DENY BENEFITS REQUIRED UNDER THIS SECTION FOR AN INDIVIDUAL WITH LIMB LOSS OR ABSENCE THAT WOULD OTHERWISE BE COVERED FOR A NONDISABLED PERSON SEEKING MEDICAL OR SURGICAL INTERVENTION TO RESTORE OR MAINTAIN THE ABILITY TO PERFORM THE SAME PHYSICAL ACTIVITY.

(K) AN ENTITY SUBJECT TO THIS SECTION SHALL INCLUDE LANGUAGE DESCRIBING THE INSURED'S OR ENROLLEE'S RIGHTS UNDER SUBSECTIONS (I) AND (J) OF THIS SECTION IN ITS EVIDENCE OF COVERAGE AND ANY BENEFIT DENIAL LETTER.

(L) (1) AN ENTITY SUBJECT TO THIS SECTION SHALL ENSURE ACCESS TO AT LEAST TWO DISTINCT PROSTHESIS PROVIDERS IN THE ENTITY'S PROVIDER

NETWORK IN THE STATE FOR PROSTHESES, PROSTHESIS TECHNOLOGY, AND MEDICALLY NECESSARY CLINICAL CARE FOR PROSTHESES.

(2) (I) IN THE EVENT THAT THE BENEFITS REQUIRED UNDER THIS SECTION ARE NOT AVAILABLE FROM AN IN–NETWORK PROVIDER, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE PROCESSES TO REFER AN INSURED OR ENROLLEE TO AN OUT–OF–NETWORK PROVIDER.

(II) 1. AN ENTITY SUBJECT TO THIS SECTION SHALL REIMBURSE AN OUT–OF–NETWORK PROVIDER AT A MUTUALLY AGREED ON RATE AFTER SUBTRACTING ANY COST–SHARING REQUIREMENTS OF AN INSURED OR ENROLLEE.

2. COST–SHARING REQUIREMENTS OF AN INSURED OR ENROLLEE UNDER SUBSUBPARAGRAPH 1 OF THIS SUBPARAGRAPH SHALL BE DETERMINED AS IF THE BENEFITS WERE PROVIDED BY AN IN–NETWORK PROVIDER.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before June 30, 2030, each entity that is subject to §§ 15–820 and 15–844 of the Insurance Article, as enacted by Section 1 of this Act, and each managed care organization providing coverage under the Maryland Medical Assistance Program shall report to the Maryland Insurance Administration and the Maryland Department of Health, respectively, on its compliance with §§ 15–820 and 15–844 of the Insurance Article or § 15–103(a)(2)(xxiv) of the Health – General Article, as enacted by Section 1 of this Act and as applicable, for calendar years 2025 through 2028.

(b) (1) The report required under subsection (a) of this section shall be in a form prescribed jointly by the Maryland Insurance Administration and the Maryland Department of Health.

(2) The form shall include the number of claims and the total amount of claims paid in the State for the coverage required by §§ 15–820 and 15–844 of the Insurance Article or § 15–103(a)(2)(xxiv) of the Health – General Article, as enacted by Section 1 of this Act and as applicable.

(c) (i) The Maryland Insurance Administration and the Maryland Department of Health shall aggregate the data required under subsection (b) of this section by calendar year in a joint report.

(ii) On or before December 31, 2030, the Maryland Insurance Administration and the Maryland Department of Health shall submit the joint report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2025.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2025.