

Information Summary and Recommendations

Prosthetics and Orthotics Coverage Mandated Benefit Sunrise Review

December 2011



Health Systems Quality Assurance

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THE SUNRISE REVIEW PROCESS

In 1997 the legislature passed House Bill 1191. This bill amended the statute on mandated health insurance benefits. The statute now requires proponents of such mandates to provide specific information to the legislature. If the legislature requests a review, the Department of Health makes recommendations on the proposal using statutory criteria. This review is done only at the request of the chairs of legislative committees, usually the House Health Care and Wellness Committee or Senate Health and Long-Term Care Committee.

The criteria for these “sunrise reviews” are contained in RCW 48.47.030. The legislature’s intent is that all mandated benefits show a favorable cost-benefit ration and do not unreasonably affect the cost and availability of health insurance. RCW 48.47.005 states, “... the cost ramifications of expanding health coverage is of continuing concern and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage.”

EXECUTIVE SUMMARY

Proposal

In 2011 the legislature requested the Department of Health review House Bill 1612, under the mandated benefit law, chapter 48.47 RCW. As written, the bill would apply to individual and group health insurance plans issued or renewed on or after January 1, 2012, that provide coverage for hospital or medical expenses. The bill would require health care plans to “provide coverage for benefits for prosthetics and orthotics that are at least equivalent to the coverage provided by the federal Medicare program and no less favorable than the terms and conditions for the medical and surgical benefits in the policy.” (See Appendix A for the Applicant’s Report and Appendix B for the draft bill.)

Background

According to the National Amputee Coalition of America (applicant), the loss or absence of a limb has a profound effect on people’s lives. Prosthetic limbs and orthotic braces provide mobility and independence to those living with limb loss. However, the applicant and others in the limb loss community are concerned about what they see as a growing trend, insurance companies reducing or eliminating prosthetics, and orthotics benefits. The applicant believes legislation is necessary to mandate prosthetic and orthotic health insurance coverage and that coverage should be on par with that provided by Medicare.

Recommendation

The Department of Health is unable to make a fully informed recommendation due to two areas of concern: (1) a lack of data provided by the applicant specific to Washington and (2) ambiguous language in the proposed legislation that could support a variety of interpretations. The department also recognizes concerns about the timing of this sunrise review as it relates to the pending federal definition of “essential health benefits” expected to be issued by the end of 2011.

SUMMARY OF INFORMATION

Proposal

In 2011 the legislature requested the department review House Bill 1612, under the mandated benefit law, chapter 48.47 RCW. As written, the bill would apply to individual and group health insurance plans issued or renewed on or after January 1, 2012, that provide coverage for hospital or medical expenses. The bill required health care plans to “provide coverage for benefits for prosthetics and orthotics that are at least equivalent to the coverage provided by the federal Medicare program, and no less favorable than the terms and conditions for the medical and surgical benefits in the policy.” (See Appendix A for the Applicant’s Report and Appendix B for the draft bill.)

Background

Between 1997 and 2009 there were more than 27,000 amputations performed in Washington, and 2,249 in 2009 alone.¹ It’s estimated that one in 190 Americans is currently living with the loss of a limb.² That would be about .5 percent of Washington’s population. Although this is a small percentage of the population, the loss or absence of a limb has a profound effect on the lives of individuals, their communities, and the state at large.

When a prosthetic limb or an orthotic brace provides a degree of mobility, independence, and activity that a person could not have without the device, the necessity for access to this restorative equipment is readily apparent. However, the applicant and others in the limb loss community are concerned about what they see as a growing trend regarding insurance coverage of prosthetic and orthotic devices.

The applicant argues insurance companies are reducing or eliminating prosthetics benefits, forcing people in need of services and equipment to either go without them or to become impoverished to the point that they qualify for Medicare or Medicaid. This shifts the burden for their health care to the taxpaying public. The applicant contends legislation is required to mandate prosthetic and orthotic health insurance coverage on a par with that provided by Medicare. Medicare provides an 80/20 reimbursement rate after a deductible has been met, with no annual limit.³

There has been a move to pass prosthetic parity legislation across the country. Nineteen states have passed laws addressing prosthetic parity, many with similar language to House Bill 1612.⁴

¹ Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases, cited by the applicant report, p. 1.

² “Estimating the Prevalence of Limb Loss in the United States: 2005 to 2050,” Archives of Physician Medicine and Rehabilitation, Vol. 89, Issue 3, March 2008, pp. 422-429, <http://www.sciencedirect.com/science/article/pii/S0003999307017480>, accessed September 6, 2011.

³Centers for Medicare and Medicaid Services, “Your Medicare Benefits,” revised January 2011, p.41, <http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>, accessed August 29, 2011.

⁴ <http://www.amputee-coalition.org/absolutenm/anmviewer.asp?a=314&z=200>. Cited by applicant report.

In addition, a bill was introduced in the U.S. Senate 2010 calling for carriers that provide prosthetics or custom orthotics benefits to provide those benefits under terms and conditions no less favorable than the terms and conditions applicable to the medical and surgical benefits provided.⁵

Public Participation

The Department of Health shared the proposal with interested parties and began accepting comments on July 15, 2011. We received eight comments in writing, including input from the Health Care Authority (HCA) on how the proposal would impact state-purchased health care. This is a summary of the comments received (See Appendix D for the full comments.):

- The Physical Therapy Association of Washington wrote in support of the proposed legislation. It requested the legislation be expanded to include all treatment, services, and supplies provided by licensed physical therapists. The association claims that without additional language allowing for coverage of treatments, services, and supplies provided by physical therapists, patients will find much of their treatment remains uncovered.
- Regence BlueShield wrote with its concerns about the proposed legislation. Many Regence group and individual plans already cover prosthetics and orthotics at regular plan levels with no benefit limits. One Regence individual plan provides coverage of orthotics. Regence estimates that the coverage in the proposal would increase the cost of an individual plan by .3 percent. Regence is also concerned about how this legislation would interface with pending federal legislation and/or rulemaking that will define “essential benefits” under the Affordable Care Act. Regence is concerned about its ability to control utilization costs if it is no longer able to employ its medical management policy.
- The Association of Washington Business wrote to urge that further action on HB 1612 be delayed until the federal Affordable Care Act is fully implemented. The Association of Washington Business pointed out that the federal Department of Health and Human Services (HHS) is required to identify the “essential benefits” new health plans must include beginning in 2014. Rehabilitative services and devices are specifically listed for required coverage so HHS will determine the extent of the coverage. Department of Health and Human Services is expected to release the new requirements before the end of 2011.
- Premera Blue Cross wrote to express its opposition to the proposed legislation. The majority of Premera’s plans cover prosthetic and orthotic devices and none of the individual or small group plans have a lifetime maximum for prosthetics. Premera suggests that action on HB 1612 be delayed until the federal HHS defines “essential health benefits” as it relates to prosthetic and/or orthotic devices. Premera is concerned

⁵ S.3223 Prosthetics and Custom Orthotics Parity Act of 2010, available at <http://www.amputee-coalition.org/absolutenm/anmviewer.asp?a=314&z=20>, accessed August 29, 2011.

about its ability to control utilization costs if it is no longer able to employ its medical management review.

- The Association of Washington Healthcare Plans wrote to express concerns about the proposed legislation. The Association of Washington Healthcare Plans is comprised of health care plans that provide coverage to four million Washingtonians. The association is concerned that the proposed legislation would prohibit health care plans from performing medical necessity reviews and leave determinations of medical necessity solely to the treating physician. It is also concerned about the potential interface between HB 1612 and the pending federal definition of “essential health benefits.”
- The Washington Occupational Therapy Association wrote to offer its support of HB 1612 if prosthetic and orthotic services and devices provided by occupational therapists are included in the proposed coverage.
- Group Health also wrote to urge delaying action on HB 1612 until the Department of Health and Human Services releases its definition of “essential health benefits” in late 2011. Group Health contracts with prosthetic and orthotic suppliers at a rate lower than Medicare’s. Group Health is also concerned that the definition of orthotic device could be interpreted to cover personal care and comfort devices that are currently not covered. Group Health is also concerned that medical necessity determinations will be solely left to physicians.
- The Health Care Authority (HCA) wrote to express its concerns about the proposed legislation. The HCA oversees public employee benefits board (PEBB) health care plans. The PEBB plans cover prosthetics but not all types of orthotics that might be required by the bill. The Health Care Authority is concerned about PEBB plans being able to continue medical necessity reviews and being able to limit high-end technological prosthetics that exceed basic needs. The HCA is concerned about a broad definition of orthotics that could result in mandated coverage of basic and custom shoe inserts, for example. It estimates that passage of HB 1612 would result in a 1 percent increase in PEBB plan costs.

A public hearing was held August 9, 2011, in Tumwater, Washington. Two presenters spoke in favor of the proposed legislation: Roman Daniels-Brown, representing the applicant; Amputee Coalition of America; and Sanjay Perti, President of the Washington Prosthetic and Orthotic Association. Melissa Johnson, representing the Physical Therapy Association of Washington, and Mark Gjurasic, representing Washington Occupational Therapy Association, spoke to their preference to specifically include these two health care professions in the proposed bill’s language. Kathy Gano, representing Premera Blue Cross, reiterated the company’s written comments. (See Appendix E for Summary of Public Hearing.)

Following the public hearing, there was a 10-day comment period and another comment period for rebuttals following the release of the draft report. We did not receive any rebuttals to the draft report.

Defining the Problem in Washington

The Department of Health finds itself in a difficult position in this sunrise review due to the lack of definitive Washington-specific data provided by the National Amputee Coalition of America (applicant). The department posed follow-up questions and inquired at the public hearing, but the applicant seems to lack the foundational information required for a full and fair analysis of the proposed legislation.

The applicant contends there is a growing trend of insurance companies restricting or eliminating prosthetics coverage. However, most of the data the applicant provided is either national or in the form of other states' studies that have evaluated similar legislation. (See Appendix A for Applicant Report.) The applicant provided few examples of companies operating within Washington that are restricting access to care. It did not support their claim that this is a growing trend in the state. The Department of Health cannot address an issue until it has adequate data to support: (a) there is a problem impacting Washington residents, (b) the scope of the problem, (c) the available alternatives for addressing the problem, and (d) the costs of addressing the problem.

Federal Law

The 2010 federal Affordable Care Act (ACA) makes substantial changes to health care coverage in the United States. Many of these changes will impact the problem the proposed legislation attempts to correct. These changes include eliminating lifetime and annual dollar limits on essential benefits. "Rehabilitative and habilitative services and devices" are expressly included as an "essential benefit," but the details of prosthetic and orthotic coverage remain to be seen. More definitive information is expected by the end of 2011.⁶

The Language of the Proposed Legislation

The Department of Health has concerns about portions of the language of the proposed bill. Several key terms are either so broadly defined or so insufficiently defined as to create a strong potential for conflicting interpretations. For example,

- **"orthotic device"**

Both at the public hearing and in the written comments, interested parties commented that there is uncertainty about what the term "orthotic device" encompasses. As it is written in Section 1(1)(a) of the proposed legislation, an "orthotic device" is a rigid and semi-rigid device that supports a weak leg, foot, arm, hand, back, or neck, or restricts or eliminates motion in a diseased or injured leg, foot, arm, hand, back, or neck.

⁶ Patient Protection and Affordable Care Act, Sec. 2707 and Sec. 1302.
<http://docs.house.gov/energycommerce/ppacacon.pdf>, accessed August 29, 2011.

This definition differs greatly from and could be interpreted to conflict with the definition of “orthosis” contained in the Orthotic and Prosthetic Services practice act, RCW 18.200.010(6). (See Appendix C for specific language.) The proposed legislation does not exempt from insurance coverage a significant number of assistive devices that are outside an orthotist’s scope of practice. If enacted as written, this conflict could put orthotists in the untenable position of being able to bill insurance for services and devices they are not authorized to offer.

There was significant concern brought up by insurance carriers that the broad definition of “orthotic device” in the proposed legislation could be interpreted to include over-the-counter or pre-fabricated foot orthotic devices. The anticipated patient demand for this type of device if covered by insurance would be very high. Medicare typically does not cover routine foot care or foot supports. However the proposed bill requires that orthotic coverage “be no less favorable than the terms and conditions for the medical and surgical benefits in the policy.” This leaves room for argument that these benefits could be included. This could result in an exponential increase in the types of assistive devices that must be covered, and much higher costs than the applicant or the Health Care Authority (HCA) have estimated.

The applicant states its intent was to exclude over- the-counter foot orthotics and to only include “prescribed orthotics.” However, the HCA provided comments that in discussions with the applicant, they were told the intention was to include orthotics that “are specifically used with prosthetics.” Confusion remains on the intent of including foot orthotics in the proposal.

- **“prosthetic device”**

As it is written in Section 1(1)(b) of the proposed legislation, a “prosthetic device” is an artificial limb, device, or appliance designed to replace an arm or a leg, in whole or in part. This definition differs greatly from and could be interpreted to conflict with the definition of “prosthesis” contained in the Orthotic and Prosthetic Services practice act, RCW 18.200.010(9). (See Appendix C for specific language.) The proposed legislation does not exempt certain types of devices from insurance coverage that are outside a prosthetist’s scope of practice, such as surgically implanted medical devices used to replace a limb or appendage. If enacted as written, this conflict could put prosthetists in the untenable position of being able to bill insurance for services and devices they are not authorized to offer.

- **“determined medically necessary by the treating physician”**

Health care insurance companies and the Health Care Authority expressed concern that the proposed legislation would limit or even prohibit insurers from performing internal

cost management reviews of medical necessity. Regardless of the intent of the applicant, there is a supportable interpretation of Section 1(2) that if a treating physician determines an orthotic or prosthetic service or device is medically necessary to restore optimal functionality to the patient, that determination is final. The proposed legislation makes no allowance for review or override by an insurance company's review board. Nor does it provide any upper limit on what constitutes optimal functionality.

- **“treating physician”**

Section 1(2) of the proposed legislation references medical necessity determinations made “by the treating physician” to restore functionality to optimal levels. However, the Orthotic and Prosthetic Services practice act references a much broader list of “authorized health care practitioners” who may order for or refer a patient for new orthoses or prostheses. RCW 18.200.010(10) defines "authorized health care practitioner" to include licensed physicians, physician assistants, osteopathic physicians, chiropractors, naturopaths, podiatric physicians and surgeons, dentists, and advanced registered nurse practitioners. (See Appendix C.) As written, the proposed legislation could be interpreted to mandate coverage at Medicare levels only when a patient was referred by a physician.

In addition, Washington Occupational Therapy Association and the Physical Therapy Association of Washington requested additional language be added to the bill to clarify that treatment, services, and supplies provided by licensed occupational therapists and physical therapists be included in the mandate.

ASSESSMENT OF THE SUNRISE CRITERIA

Social Impact

To what extent is the benefit generally utilized by a significant portion of the population?

The applicant estimates less than 16,000 current Washington residents would use the benefit proposed. Future projections were not provided.

To what extent is the benefit generally available?

Most insurance plans have some type of prosthetic and orthotic coverage. The applicant's position is that plans are trending toward reducing or eliminating the coverage. The applicant did not present adequate evidence specific to Washington to show this trend.

If the benefit is not generally available, to what extent has its unavailability resulted in people not receiving needed services?

The applicant did not present any evidence that people aren't receiving needed prosthetics or orthotics.

If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

The applicant contends that restricted prosthetic and orthotic coverage is forcing people to either impoverish themselves to pay privately for the equipment and services, or to reduce their financial and employment status to qualify for public coverage. The applicant did not present evidence specific to Washington.

What is the level of public demand for the benefit?

The applicant did not provide evidence of public demand for this benefit.

What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

The applicant did not provide this information.

Financial Impact

To what extent will the benefit increase or decrease the cost of treatment or service?

The benefit may make prosthetics and orthotics more affordable in some cases. However, it will also likely result in a health insurance premium increase for subscribers and increased costs for insurance plans as a result of mandated coverage.

To what extent will the coverage increase the appropriate use of the benefit?

The benefit will not increase the number of people needing prosthetics or orthotics, but it could increase access and affordability to the devices.

To what extent will the benefit be a substitute for a more expensive benefit?

The benefit will not directly substitute for a more expensive benefit. However, the applicant points out that when people are able to lead more active and independent lives with the assistance of prosthetic and orthotic devices, the health care costs associated with sedentary lifestyles are reduced.

To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders?

The applicant did not provide information about the administrative expenses of health carriers. Anticipated premium increases nationally and in Washington are estimated from less than 1 percent up to 1 percent.⁷

What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage?

The applicant did not provide information about the impact of this benefit on the total cost of health care services. The applicant provided an estimated increase of .025 percent based on a similar mandate in New Jersey (See Appendix A).

What will be the impact of this benefit on costs for state-purchased health care?

According to the Health Care Authority (HCA), the public employee benefits board (PEBB) plans cover prosthetics. They do not provide coverage for all types of orthotic devices that may be required in the current bill if enacted. Group Health of Washington commented to the HCA that the broad language in the proposed bill could increase premiums by one percent. It also estimates a one percent increase for PEBB plans.

What will be the impact of this benefit on affordability and access to coverage?

The impact on affordability and access to coverage is a point of contention between the applicant and the insurance companies who provided written comments. The applicant contends that the proposed legislation is required to guarantee access in the face of dwindling coverage. The insurance companies contend that the majority of their policies already provide broad prosthetic coverage and some degree of orthotic coverage.

Evidence of Health Care Service Efficacy

If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?

Not applicable. The efficacy of using prosthetic and orthotic devices is not at issue. In addition, we are not looking at only one specific device, but a range of devices.

⁷ Fiscal note on HB 1612, <https://fortress.wa.gov/ofm/fnspublic/legsearch.asp?BillNumber=1612&SessionNumber=62>, accessed August 29, 2011.

If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

Not applicable. This proposal does not seek a mandated benefit of a category of health care providers.

To what extent will the mandated benefit enhance the general health status of Washington residents?

The mandated benefit would directly impact a small number of people, so its effect on the general health status of Washington residents would be negligible.

DETAILED RECOMMENDATION

The Department of Health is unable to make a recommendation on this proposal because the sunrise criteria were not adequately addressed, nor was the need for the proposed mandate adequately identified.

Rationale:

Social Impact

The applicant failed to provide adequate data specific to Washington to address the social impact of the proposal.

Financial impact

The ambiguous language in the proposed legislation could support a variety of interpretations, especially relating to orthotics. Depending on which interpretation of orthotics is applied, the population impacted could be enormous, causing a much larger increase in premiums than already projected.

Evidence of Health Care Service Efficacy

This criterion was not addressed because it was not applicable. Efficacy of a specific device or service was not at issue.

Additional Consideration

Coverage and benefit limits on prosthetics and orthotics are expected to be addressed as a result of the Affordable Care Act. In implementing the act, the federal government has stated it will release its list of essential health benefits in late 2011. We believe these devices will be part of the essential health benefits that plans will be required to cover, but we don't know at what level.

Challenges if Enacted

If the legislature chooses to enact this mandate, the department believes the following clarifications should be added to the proposal:

- Narrow the definition of “orthotics” in 1(a) to include only those used with prosthetics. The applicant provided an example of language used in Indiana that might suffice. “Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.”
- Clarify the language around medical necessity in (2) to ensure health carriers retain the ability to perform their cost management reviews of medical necessity.
- Make sure all providers authorized by law to order for or refer a patient for new prosthetics or orthotics are included in the law.
- Ensure the definitions of orthotic and prosthetic devices do not conflict with those already contained in the Orthotic and Prosthetic Services law.
- Ensure that treatment, services, and supplies provided by licensed occupational therapists and physical therapists are included.

Appendix A

Applicant Report

Evaluation of the Impact of the Proposed Washington Prosthetic and Custom Orthotic Parity Bill

Prepared by the Amputee Coalition
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(a) Social Impact

(i) To what extent is the benefit generally utilized by a significant portion of the population?

According to The Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), the prevalence of amputations in Washington was 2,249 amputations in 2009. It was also reported that there have been a total of 27,065 amputations between 1997 and 2009 in the state of Washington. While this figure does not take into account the limb loss population prior to 1997, and the figure may be slightly higher, this is the most accurate data currently available.

According to the Washington State Office of Financial Management, 3.5% of Washingtonians are covered by individual insurance, and 56% are covered by employer based plans. The proposed legislation would impact both private insurance and those employer-based plans regulated by the state. Using these numbers, and the amputation data from 1997 to 2009, an estimated 16,105 amputees would be impacted by this bill (948 covered by individual insurance and 15,157 under employer based plans).

This number would actually be lower since a set of employer based plans are regulated by the federal government and would not be impacted by the proposed legislation. However, a federal bill is also being introduced that would seek to roll these plans into the regulations down the road.

While this is a small segment of the population, the current situation impacts a much larger population due to loss in wages and the cost shifting from private to public care. Furthermore, the impact of the proposed legislation would make a dramatic improvement in the lives of individual amputees.

It is important to note that 35.8% of the insured population is covered by public programs such as Medicaid or Medicare (9,690 amputees). These programs already provide comprehensive orthotic and prosthetic care.

(ii) To what extent is the benefit already generally available?

The Veteran's Administration, the Department of Defense, Workmen's Compensation insurance, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), state vocational rehabilitation and many automobile insurance policies already cover this area of care.

The purpose of this bill is to overcome restrictions and exemptions that are being imposed by companies related to prosthetic care. While many companies are covering prostheses, we have seen a trend in restricting or eliminating coverage.

A poll of the Amputee Coalition's web site found that 423 (72%) respondents had private insurance.

- Of the 423 with private insurance, 31% had experienced a reduction in their prosthetic coverage.
- 7% of the respondents had their prosthetic coverage eliminated entirely.

In an online survey conducted in June and July 2007, the Amputee Coalition found that insurance coverage was reduced for 29 percent of respondents and eliminated for 8 percent of respondents.

(iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

There are several companies operating within the state of Washington that are currently restricting access to care including Aetna, Cigna, Blue Cross Blue Shield and United Healthcare. Attached you will find the survey on national coverage restrictions.

This is a compilation of different types of restrictions that were found on prosthetic coverage in private insurance plans.

Financial Restrictions	Exclusions	Co-Pays
\$5,000 cap per year	Coverage for repairs	50% co-pay
\$1,000 cap per year	Coverage for replacements	Patient pays 50% of the costs for prosthetics
One prosthesis per lifetime	A max out on benefits if the patient had received a prosthesis from another insurance company	\$1,500 annual out-of-pocket
\$2,500 cap per calendar year	20% reimbursement	\$2,000 out of pocket to receive any coverage
50% of cost for DME	No coverage for the C-Leg	\$500 deductible and \$2,000 out of pocket to receive any coverage
\$2,500 max lifetime cap	No coverage for above elbow myoelectric prosthesis.	
\$7,000 max lifetime cap	No coverage for biomechanical devices	
\$7,500 cap per year	No coverage for above elbow myoelectric prosthesis.	
\$2,500 cap per year	No coverage for biomechanical devices	
\$3,500 cap over 3 years	Limitations on myoelectric upper extremity prosthetics.	
\$2,500 cap every three years	Battery replacements are not covered	
\$3,500 annual benefit limit for		
\$15,000 annual benefit limit		
\$40,000 lifetime benefit limit		
\$50,000 lifetime benefit limit		
\$5,000 annual benefit limit		
\$10,000 maximum per occurrence		
One prosthesis every three years and \$5,000 limit		
\$10,000 lifetime cap		
\$65,000 lifetime cap		

(iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

When people discover that prosthetic care isn't covered, they may be forced to use retirement or children's college savings to buy the prosthesis they need to go to school, go to work, go to church and live their lives. Some take out home mortgages, bank loans, or even use high interest credit cards to get their prosthesis.

There are a number of private foundations that provide assistance, but these are only for the most severe cases of poverty and need. That leaves your working population and middle class families without assistance when their insurance company denies coverage.

Insurance companies are shifting the cost of care to the state. They receive the premiums from individuals, but when the coverage is denied amputees are accessing state Medicaid and vocational rehabilitation programs to get the prosthesis they need.

For many people, lack of access to care may result in losing their job. This has a financial impact on the individual and their family. It also results in a loss of tax revenue.

(v) What is the level of public demand for the benefit?

There is a strong push nationally for prosthetic parity legislation.

- Nineteen states have passed prosthetic parity laws.
- Over 20 more states are working to introduce or advance bills.
- A bill has been introduced in Congress with bipartisan support in each of the last two congressional sessions and will be reintroduced in the 112th Congress.
- We have strong support from a diverse range of coalition partners including the American Diabetes Association and Families USA.

We have strong support from providers in the state of Washington. Furthermore, the professional organizations representing prosthetists and the organization responsible for accrediting prosthetists are in support of this bill.

- American Orthotist & Prosthetist Association (AOPA)
- American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC)

Additionally, we have had the support of several prominent groups in the health care field including:

- American Academy of Family Physicians
- American Medical Association
- American Congress of Rehabilitative Medicine
- American Physical Therapy Association

(vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

We have surveyed companies to determine the general availability of care. We have not studied the process by which that care has been determined within specific plans.

(b) The Financial Impact

(i) To what extent will the benefit increase or decrease the cost of treatment or service?

Optional policies spread the risk pool over a small number of persons that need to access the benefit and result in policies that are prohibitively expensive to the individual. By treating orthotic and prosthetic care on par with other basic, medical services, the cost is shared across the general insurance population.

The cost of a prosthesis is very low in relation to a large insurance pool in which reimbursements are being made for things like bypass surgery or a hip replacement. However, without insurance coverage, many amputees are unable to afford to cover the entire expense of a prosthetic device.

(ii) To what extent will the coverage increase the appropriate use of the benefit?

Unlike many bills designed to expand coverage for a health care service, prosthetic parity legislation will not increase utilization. Many bills that provide coverage for care will result in more people accessing the care such as a bill that covers mental health services. No one is going to try to access this care merely because it is now available. The way that we often explain this is that no one is going to cut off his or her arm or leg in order to access a prosthetic or custom orthotic coverage benefit.

In summary, prosthetic and orthotic coverage would increase the availability, but not the utilization of the devices.

(iii) To what extent will the benefit be a substitute for a more expensive benefit?

Without prosthetic care, many individuals will lead a more sedentary lifestyle. This leads to countless secondary complications.

- The incidence of diabetes-related complications is increasing. Medications for these conditions can cost up to \$1,000 per month. If someone becomes an amputee at age 55 and lives to be 77, that's \$264,000.
- If someone suffers a heart attack due to peripheral vascular disease, surgical treatment and hospitalization can cost from \$75,000 to \$200,000, depending on procedures used and the patient's life span.
- If a person develops knee or hip problems from being unable to walk correctly, resulting costs can range from \$80,000 to \$150,000 or more over a lifetime, depending on the care that is needed.
- Crutch overuse can cause wrist, elbow and shoulder problems. The cost for a simple carpal tunnel wrist surgery averages about \$7,500; elbow surgery averages \$16,000 and shoulder surgery averages \$25,000.

(iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders?

Regarding administrative costs, insurance companies currently receive a countless number of appeals related to restrictions on prosthetic care. By putting prostheses on par with other basic, medical services the number of appeals the company must process and therefore expend money on would be decreased.

Furthermore, it would also save the prosthetist's office a great deal of time and money. Currently, administrative staff in prosthetic facilities spend a significant amount of time processing appeals for coverage for individual patients and helping them find alternate means of coverage.

Utilization review is often a concern or consideration in terms of the administration of a health benefit. This is not an issue for prosthetic care. Medicare has developed a well-tested and effective system for utilization management. This is the same system used by physicians and prosthetists working to prescribe care for a privately insured amputee.

The Level II or "K-Modifiers" organize components and amputees' access to them based on the patient's rehabilitation potential as determined by the prosthetist and ordering physician. Criteria considered for assessing the functional level include the patient's past history and current condition including the status of the residual limb, the nature of other medical problems, and the patient's desire to ambulate.

Classification levels are:

K0 (Level 0) - Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K1 (Level 1) - Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

K2 (Level 2) - Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

K3 (Level 3) - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic use beyond simple locomotion.

K4 (Level 4) - Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. Because of their greater rehabilitation potential, amputees in higher levels are generally allowed better choices of prosthetic components, while prostheses are denied as not medically necessary if the patient's potential functional level is "O." Exceptions are considered in individual cases if additional documentation is included that justifies the medical necessity.

(v) What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage?

The cost/benefit data demonstrates how inexpensive it is to provide orthotic and prosthetic care, as well as the potential savings or provision. We have studies from several other states including Texas, Massachusetts, Colorado, California, New Jersey, Virginia, Maryland, Nebraska, and Maine. We have included information in this packet related to their findings.

Summary:

- The increase in premiums was found to be about 12 cents per member per month. The New Jersey study (attached) contained coverage for orthotic and prosthetic coverage, and it was found that premiums would increase by just .025% of the premium.
- There may also be a cost savings in both the private and public sector due to savings in spending on complications related to a lack of prosthetic or orthotic care. The public sector would also save money in Medicaid and vocational rehabilitation dollars.
- The provision of prostheses results in a variety of benefits, some of which are fiscal in nature; some of which are more related to quality of life issues, which are less measurable.

(vi) What will be the impact of this benefit on costs for state-purchased health care?

Currently, insurance companies are shifting the cost of care to the state. They receive the premiums from individuals, but when the coverage is denied amputees are accessing state Medicaid and vocational rehabilitation programs to get the prosthesis they need.

For many people, lack of access to care may result in losing their job. This has a financial impact on the individual and their family. It also results in a loss of tax revenue.

The cost of these secondary conditions on the health care system far outweighs the cost of covering the prosthesis. Furthermore, the provision of prosthetic services should be viewed as restorative. Other states have found that curtailing or eliminating coverage of these vital services actually cost them more money in the long run. In summary, the state actually saves money in the long run by covering prosthetic and custom orthotics, (see Colorado study).

(vii) What will be the impact of this benefit on affordability and access to coverage?

Without proper coverage, prostheses are out of reach for many amputees at this time. By requiring that prosthetic care is covered, all those who are covered under private insurance would be able to access appropriate care to fit their needs.

(c) Evidence of health care service efficacy

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?

As you may imagine, there have not been controlled trials done that use a sample population and other typical methodologies as might be used with a pharmaceutical trial. We are talking about a person having a limb or not having a limb. There is certainly data available about the implications is someone is not provided with appropriate care.

Without prosthetic care, many individuals will lead a more sedentary lifestyle. This leads to countless secondary complications. If amputees are prevented from accessing the care they need to be productive members of society, it may lead to complications such as flexion contractures, skin breakdown, osteoporosis, muscle loss, and depression, along with costs associated with nursing home and/or home care. The subsequent cost to the healthcare system far exceeds that of providing prosthetic care, while the lack of productivity places a huge burden on society.

The provision of prostheses results in a variety of benefits, some of which are fiscal in nature; some of which are more related to quality of life issues, which are less measurable. Non-fiscal benefits include a reduction in the secondary conditions caused by a sedentary lifestyle, decreased dependence on caretakers, and reduced chance of diabetic-related complications leading to additional limb amputation.

(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

There are an adequate number of providers and suppliers for prosthetic care. These providers are certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC). ABC is the national certifying and accrediting body for orthotists and prosthetists. There are 35 ABC accredited facilities and 251 credentialed providers in the state of Washington.

The education requirements for ABC practitioner certification are the only prosthetic educational standards recognized by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). Practitioners are also required to participate in continuing education programs.

(iii) To what extent will the mandated benefit enhance the general health status of the state residents?

This benefit is specific to amputees, however the provision of prosthetic care will result in a savings to the public and private sector. This has a positive impact on the general population.

Additional Information

- Regarding Impact on Employability of Users

If amputees are prevented from accessing the care they need to be productive members of society, it may lead to complications. The subsequent cost to the healthcare system far exceeds that of providing prosthetic care, while the lack of productivity places a huge burden on society.

The provision of prosthetic services should be viewed as restorative. Other states have found that curtailing or eliminating these vital services have actually cost them more money in the long run. Prosthetic coverage laws returned people to work and saved money for the states passing it.

- Balancing the Social, Financial and Medical Efficacy Considerations

Prosthetic coverage laws put prosthetics where they belong — on par with other critical medical services in people's health insurance plans. The basic theory of health insurance in this country is that we pay into a pool each month. We may not need anything more than a check-up, but we pay the money each month in case an urgent need may arise. And when we are in need of urgent care, the expectation is that we will get that care in return for the premiums we have paid in each month.

This concept accepts the fact that not everyone needs the same care. Many people will not need treatment for a stroke, but they pay into the plan and it is covered when someone within the pool has a stroke. People understand that they pay into a pool to cover critical health services. Given that prosthetic care is not only restorative, but also prevents many costly and deadly secondary conditions, it should certainly be seen as a critical health service.

ENCLOSED

- Fact sheet
- One pager
- Data supporting prosthetic and orthotic coverage legislation
- Other state studies on related legislation

Resources

- 2000 N.O.D./Harris survey of Americans with disabilities / sponsored by Aetna, Inc. and the JM Foundation ; conducted for National Organization on Disability.
- Amputation Statistics by Cause: http://www.amputee-coalition.org/fact_sheets/amp_stats_cause.html

- A Survey of Upper-Limb Prosthesis Users in Oxfordshire:
http://www.oandp.org/jpo/library/1998_04_085.asp
- A Brief Introduction to Lower Limb Prosthetics: <http://www.bbc.co.uk/dna/h2g2/A8465574>

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27. University of Missouri *Handbook of Disabilities*

Attachments to Applicant Report (Appendix A)

Insurance Fairness for Amputees

Purpose:

To provide the limb loss community with access to prosthetic and orthotic care through their employer-based and private insurance companies by eliminating the arbitrary caps, restrictions and exemptions companies currently impose. While some private insurance companies have adequate coverage, there has been an alarming trend in restricting or eliminating this coverage thereby making this necessary care inaccessible to many people with limb loss.

Need for law:

- It is estimated that there are more than 2 million amputees currently living in the United States.
- Approximately 507 people lose a limb in the United States every day.
- Every year more than 700 children lose a limb due to lawn mower accidents.
- The American Diabetes Association estimates that 7.8% of the population in the United States has diabetes, which is the leading cause for amputation, leading to a potential increase in individuals who may need this care.
- Common caps and restrictions on prosthetics include \$2,500 per year, \$5,000 per year, or even as minimal as one limb per lifetime.

What is the current level of care?

Prosthetics and orthotics are currently covered under the durable medical equipment category in most insurance policies, which means prosthetics and orthotics are categorized with equipment such as crutches, wheel chairs, walkers, and hospital beds and they are then subjected to the same caps and restrictions listed above. However, prosthetics and orthotics, unlike some of the other items included in durable medical equipment, provide an unmatched level of restoration and ability for independence as compared to a walker, a crutch, or a wheel chair. Prosthetics and orthotics should be treated as a restorative treatment much like an artificial knee, hip, or shoulder, or a pacemaker. Insurance covers all of these restorative items at fair levels. Prosthetic and orthotic devices should be treated the same way.

What would this law do to change the current level?

This law would make sure that prosthetics and orthotics are treated as a necessary item that restore function for individuals and allow them to remain active, contributing members of society. Insurance companies don't tell someone they could only have \$2,500 of care for a pace maker, or that they could only have one joint replacement per lifetime, they should not do this for prosthetics and orthotics. This law would essentially take prosthetic devices out from the durable medical equipment category and treat them like any other benefit in the policy.

The reason for purchasing health insurance is to cover the costs in the event of a catastrophic illness or injury. Certainly the loss of a limb would qualify as such a circumstance. This law would allow people to have adequate coverage for a device that is deemed medically necessary by a treating physician to restore function for the patient. Unfortunately people are often unaware of their coverage for prosthetic devices until it's too late.

Are there other options for people that need coverage?

There are many programs that do currently cover prosthetic devices aptly, and they include:

- Medicare
- Most state Medicaid programs
- The Veterans Administration
- Many state worker compensation and rehabilitation programs

Cost of providing coverage as found by other states:

Several state legislatures have commissioned studies which have shown that by providing this important coverage, the increase in premiums would be minimal averaging out to an increase of just 14 cents per member per month.

- *Department of Health Policy & Planning Report, Colorado* found that, “the maximum increase in premiums would be about 12 cents per member per month (PMPM). This cost estimate did not take into account that there would be a cost savings by both the private and the public sector.”
- California’s analysis stated that, “because these savings are less than 0.01% of total premiums in the small-group market, we assume that employers would not respond to such a small potential savings (by cutting off the insurance).”
- *Hewitt Associates LLC Trends in HR and Employee Benefits: Prosthetic Parity* found “the average premium increase across all plans would be \$0.16 PMPM. The average premium increase that employers would actually pay, according to the California Health Benefits Review Program, would be around \$0.11 PMPM across all plans.”
- *Analysis of SB 931 (Virginia): Orthotic and Prosthetic Devices* said “Estimates in Virginia were even lower (*than other state studies*) with PMPM impacts between \$0.02 and \$0.08.”
- *The Evaluation of Senate Bill 931, JLARC of Virginia’s General Assembly* found that “amputees who have access to prosthetic devices show a reduction in the secondary conditions caused by increased sedentary lifestyle, have decreased dependence on caretakers, and a reduced chance of additional medical complications leading to further amputations.”
- *JLARC* also found that “mandating coverage under SB 931 is not expected to increase the number of individuals seeking care through Virginia’s Medicaid program, and has the potential to reduce the number of individuals that may seek Medicaid coverage” and “the proposed mandate is not expected to have a significant impact on overall healthcare costs in Virginia and may reduce total overall costs.”

Conclusion:

Insurance companies should be adequately covering prosthetic devices for individuals instead of using arbitrary caps and restrictions. These devices allow people to remain active, contributing members of society instead of dependent on it. This law would also have the potential to decrease state spending on prosthetic care, and decrease the amount spent on secondary conditions that result from a sedentary lifestyle. Not only is it the right thing to do, but it’s the smart thing to do.

Key findings from independent state studies on Insurance Fairness for Amputees:

Joint Legislative Audit and Review Commission of Virginia's General Assembly:

Other states that have reviewed similar mandates have estimated the premium impact on the consumer to be between \$0.12 and \$0.35 per premium per month. Estimates for Virginia were even lower; with per premium per month impacts between \$0.02 and \$0.08...

...This median premium estimate amounts to less than one one-hundredth of a percent of the average monthly premium for a standard single individual contract (\$214), as defined in the BOI's 2005 report on the financial impact of mandated health insurance benefits.—p. 19-20.

Massachusetts Division of Health Care Finance and Policy:

Compass Health Analytics Inc. estimates that over the next five years the average cost for this mandate would range from \$5.3 million to \$9.0 million, with a mid-range estimate of \$6.5 million; premiums would increase by an average of \$0.41 over the same time frame. – p. 1

On an annual per member per year basis, the comparable numbers are low and high estimates of \$0.32 and \$0.64, with a mid-range estimate of \$0.42. – p. 7

Maryland Coverage of Prosthetic Devices Study:

Mercer summarized the potential cost of the legislation as follows:

The estimated full cost as a percentage of average cost per group policy is .08% while the marginal cost was found to be .04%. The estimated full **annual** per member cost was found to be \$0.25, while the marginal cost was found to be \$0.13 – p. 16

Review and Evaluation of Required Coverage for prosthetics – Nebraska:

Based on our analysis, our understanding of the situation in Nebraska, and the current average cost of a prosthetic, we estimate that the average premium increase would be in the range of 0.03% to 0.06%.

Considering the average premium in Nebraska, this would result in an average increase in group premium for individual coverage of \$0.17 PMPM and for family coverage of \$0.48 PMPM. – p. 18

Mandated Health Benefits Advisory Commission – New Jersey:

Based on the marginal cost of this mandate, the increase in premiums is expected to be **less than** 0.025%. – p. 21

California Health Benefits Review Program:

Premiums are expected to increase by 0.054%, or \$0.152 PMPM. Increases in insurance premiums vary by market segment, ranging from approximately 0.034% to 0.098%. Increases as measured by PMPM payments are estimated to range from approximately \$0.097 to \$0.258. – p. 7

The full studies are available online at:

<http://www.amputee-coalition.org/absolutenm/anmviewer.asp?a=314&z=20>

Independent State Cost Estimates Relating to the Addition of Orthotic and Prosthetic Parity in Insurance Policies and Coverage

The question this paper addresses is: Given that many health plans provide some orthotic and prosthetic benefit, what would be the cost of proposed legislation to provide parity for orthotic and prosthetic devices? The conclusion is the estimated cost is five cents per member per month, or 60 cents per member per year. This amount does not include savings from improved health or reduced state Medicaid expenses. It also does not take into account that a number of states have enacted orthotic and prosthetic parity laws already which means that these incremental costs have already been incurred in those states.

Executive Summary

This paper contains selectively reviewed and excerpted key aspects from a series of twelve publications, generated either by State agencies, or by contractors selected and funded by State legislative resources, estimating the costs of orthotic and prosthetic (O&P) parity.

“Parity” refers to the concept of offering health insurance coverage for orthotic and prosthetic (O&P) devices that is equal to, or on par with, the coverage extended for other medical and surgical services. Parity would prevent benefit plans from placing often unrealistic dollar limits or caps on the coverage of and payment for O&P devices.

A Federal proposal is currently pending to establish orthotic and prosthetic parity, and would provide a mandate for benefit plans to adopt Medicare’s coverage and payment guidelines as the minimum benefit level that can be offered. The information below should serve to answer questions related to the cost of such a proposal.

From data compiled by Morrison Informatics that, *if* no insurer provided payment or coverage for O&P services, the cost of parity would be about \$0.30 per member/per month (PMPM) for prosthetics, and \$0.31 PMPM for orthotics, or just over \$7.00 per member/per year. However, because many benefit plans already offer some level of orthotic and prosthetic coverage, *the additional, or incremental, costs resulting from the passage of parity legislation would be much less.* Understanding exactly *what* those costs are is important to the argument in favor of parity.

Fortunately, abundant data exists from the states that have conducted independent studies under the direction of their legislatures to answer more precisely and reliably questions surrounding the costs of O&P parity.

Key points derived from twelve independent state analyses are below. Further information on each of the analyses is offered at the end of this document.

Information derived from several state studies shows nearly 90 percent of insurers offer some type of benefit that covers O&P care. However, in many cases, the coverage available is subject to caps and limitations so the coverage does not meet the standard of comparability to the plan's medical and surgical coverage.

Data from California shows the incremental cost of raising existing coverage to the proposed statutory standard will consume just 14.86% (e.g., 11/74) of the total cost of all orthotic and prosthetic care. Coupling this measure with the Morrison Informatics data demonstrates the actual cost for all of the incremental improvements necessary to meet the proposed standard and to achieve parity would cost somewhere around \$0.09 PMPM, or just over \$1.00 per member/per year.

Data from NovaRest shows that a New Jersey bill that resembled the Federal proposal, when enacted, was expected to result in average premium increases of 0.025%, or about 25 cents per \$1,000 in annual premiums. This figure is consistent with the estimated costs of a similar benefit proposed in Maine: 0.03% of premiums, based on Maine's current coverage for O&P).

The information gathered by Virginia's Joint Legislative Audit and Review Commission includes data obtained directly from insurers. That study showed even lower projections of the incremental costs—somewhere between \$0.02 and \$0.08 PMPM. Studies also show that there are projected savings to insurers and/or the health care system in general that would offset at least some of these incremental costs. Several states make the assertion that any increase in premium cost will be so negligible that they did not believe parity would prompt businesses or individuals to drop health insurance coverage completely. One study showed that the physical and mental health benefits derived from the ability to exercise, work, and participate in other activities of daily living with the assistance of O&P devices would result in fewer physician visits and medical and surgical claims. The savings gained there are greater than the cumulative cost of any incremental premium increases due to O&P parity.

If we use the Maine study's assumption of a typical annual premium of \$2400 and apply the New Jersey Novarest analysis showing an incremental impact of a \$0.025% premium increase, the total cost of O&P parity would be 60 cents per member per year. This is a median estimate, roughly midway between the higher California/Morrison composite-based projection of \$1.08 per beneficiary per year; and the lower Virginia estimate of \$0.24 per beneficiary per year.

References and Source Materials

1. California Health Benefits Review Program, “Analysis of Assembly Bill 2012: Orthotic & Prosthetic Devices, April 11, 2006

Currently, there are 14,049,893 individuals under age 65 with coverage for O&P devices in health plans affected by the mandate. The total per member per month (PMPM) cost of O&P devices is \$0.65 for a typical insured population. This is based on Milliman national claims data which indicates a utilization rate of 40.4 procedures per 1,000 members and an average allowed cost of \$193 per procedure.—pp. 2-3.

Nationally, about 4.5 million people rely on an O&P device, such as an artificial limb or back brace, to function more independently and improve their quality of life.—p.4

Nationally, Medicare regulations specify that payment for custom-fabricated orthoses and prostheses are furnished only by qualified providers. If the qualified provider is an orthotist or prosthetist, he or she must meet the certification standards of the ABC, or BOC, or a program with essentially equivalent standards.—p.5.

California Health Benefits Review Program (CHBRP) surveyed the seven largest health plans and insurers in California regarding their coverage levels and contracting arrangements for those who prescribe and furnish O&P devices.—p.9.

Research has also found that amputations and limb deficiency are more common in males than females and more common in blacks compares to whites (Dillingham et al., 2002; MMWR, 2001). p. 13.

2. California Health Benefits Review Program, “Analysis of Assembly Bill 2012- Amended: Orthotic & Prosthetic Devices,” June 15, 2006

At present, CHBRP estimates that for a typical insured population, O&P devices and services have a total per member per month (PMPM) cost of \$0.74, of which \$0.16 is for prosthetic devices and \$0.57 is for orthotic devices.* The estimated average annual cost per prosthetic user is considerably more than per orthotic user (\$965.40 vs. \$291.31), but there are far fewer prosthetic users per year (2.0 users per 1,000 members) than orthotic users (23.7 users per 1,000 members). Although orthotic devices represent approximately three-quarters of the PMPM cost for a combined O&P benefit, costs are not reduced proportionately by eliminating annual benefit limits across the O&P benefit since prosthetic devices typically cost more than orthotic devices. pp. 6-7.

**These results do not correlate with the 2009 Morrison Informatics computation of total PMPM for prosthetics & orthotics devices (about \$0.30 PMPM total for prosthetics, and \$0.32 PMPM total for orthotics), and one major reason is that California’s legislation related to ALL orthotics, whereas the pending federal legislation, analyzed by Morrison, is limited to customized orthotics.*

Using the responses of the six carriers that replied to the survey, CHBRP determined that 13,692,000 (93.4%) individuals have some coverage for O&P and 962,000 (6.6%) have no coverage. Of the 13,692,000 individuals with O&P coverage, 57.6% (8,447,000) have a plan that is not compliant with AB 2012 because they face higher co-insurance for O&P devices and services than for other medical benefits, or because they face annual benefit limits, or both.—p. 24.

Because these savings are less than 0.01% of total premiums in the small-group market, we assume that employers would not respond to such a small potential savings (by cutting off the insurance).—p. 28.

3. Analysis of Assembly Bill 2012 Amended: Orthotic and Prosthetic Devices—California

Referring to the study's finding that O&P coverage has a total per member per month (PMPM) cost of \$0.74, together with the fact that 93.4% of individuals had plans that were already paying some coverage for O&P, the real issue becomes the incremental cost to move from the existing coverage to O&P coverage that is on the same basis as medical and surgical coverage, about which CHBRP's analysis said "...the average portion of the premium paid by the employer would only increase by about \$0.08 and \$0.19 (\$0.11 across all plans)." A substantial portion of the increase in insurance premiums resulting from AB 2012 (California bill) can be explained by insurance absorbing a portion of the benefit cost previously paid out of pocket by insured members.—p.1

4. Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council, House Bill 317, Prosthetic Devices

The Amputee Coalition of America (ACA) stated that the existing caps private insurance companies have in place, such as one limb per lifetime, \$2,500 per lifetime and \$500 per year, are unrealistic, and the purpose of the bill is to overcome such limitations and exclusions, which render coverage inadequate. ACA also noted that some insurers are reducing prosthetic coverage or eliminating it altogether. In a 2007 online ACA survey, 29% of respondents indicated that their prosthetic coverage had been reduced, and 8% indicated that it had been eliminated.—p. 6.

The cost of mandating orthotic and prosthetic coverage (the average portion paid by members through cost sharing, including the portion over any annual benefit limit) would be between \$0.15 and \$0.25 per member per month (PMPM).—p.14.

New Jersey's Mandated Health Benefits Advisory Committee found that mandating coverage for prosthetic and orthotic devices would result in average premium increases of \$0.025 per \$1,000 of premium.—p.16.

5. Hewitt Associates LLC, “Trends in HR and Employee Benefits: Prosthetic Parity”

Most states indicate that there would be a initial, yet very slight, increase in premiums per member per month, but also some degree of savings from preventing other conditions or complications.—p.1.

The average premium increase across all plans would be \$0.16 per member per month. The average premium increase that employers would actually pay, according to the California Health Benefits Review Program, would be around \$0.11 per member per month across all plans.—p.2.

6. Department of Health Policy & Planning Report, Colorado

(T)he maximum increase in premiums would be about 12 cents per member per month. This cost estimate did not take into account that there would be a cost savings by both the private and the public sector.—p.1.

7. Analysis of SB 931 (Virginia): Orthotic and Prosthetic Devices

Other states that have reviewed similar mandates have estimated the premium impact on the consumer to be between \$0.12 and \$0.35 per premium per month. Estimates in Virginia were even lower; with per premium per month impacts between \$0.02 and \$0.08.—p.1.

8. Commonwealth of Massachusetts, Mandated Benefit Review, H. 837, Division of Health Care Finance and Policy, April, 2005

Currently, all Massachusetts insurers provide some level of coverage of prosthetic devices, ranging from unlimited coverage to a maximum annual limit of \$1,500 per member. Premiums would increase by an average of \$0.41 over the next five years.—p.1.

The increase would disproportionately affect plans offering the least coverage currently.—p.6

9. Actuarial Assessment of Massachusetts House Bill No. 376, Prepared by Compass Analytics, January 31, 2005

If the bill passes, it would affect disproportionately the plans that currently do not match the Medicare standard and need to raise their coverage levels.—p.1.

Because some plans already have coverage levels for prosthetic devices that approach the mandated levels, the impact of the mandate will fall primarily on those plans that currently offer limited coverage for prostheses.—p.7.

On an annual per member per year basis, the comparable numbers are low and high estimates of \$0.32 and \$0.64, with a mid-range estimate of \$0.42 (annual number, which breaks down in premium increase of \$0.035 per beneficiary/per month).—p.7.

10. A Study of Assembly Bill A-1011, New Jersey State Mandated Health Benefits Advisory Commission.

The NovaRest analysis indicates that this bill, if enacted, would result in average premium increases of \$0.025%.—p.1.

However, several carriers have indicated that their coverage automatically or optionally covers these appliances to the level required by A-2774.—p.4.

Novarest arrived at an overall short-term estimate of .025% of premium (or 25 cents per \$1,000 of premium). As an upper limit, one carrier reported that the total cost of providing such benefits was .08% of premium (emphasis added)—p.5.

11. A Report to the New Jersey Mandated Health Benefits Advisory Commission, Assembly Bill A-2774, Prosthetic and Orthotic Appliances, Donna Novak, CFA, ASA, MAAA, MBA, NovaRest Consulting

There may be reduced mental health care costs and disability costs due to the successful impact of the prosthesis (Maine Bureau of Insurance, “Review and Evaluation of LD 125, an Act to Promote Fairness and Opportunity for Working Amputees”). It is expected that improved use of prosthetics will result in individuals experiencing less depression and allow more individuals to return to work.—p.2.

Based on national statistics of limb loss and prosthetic use, we estimate that approximately 0.21% of the under age 65 population use orthotics or prosthetics. Some carriers currently cover these benefits at the level required by A-2774 and others cover them with some restrictions. WellChoice and Guardian report that they currently cover the benefits required by A-2774. Cigna offers a rider to its large group plans that covers the benefits required by A.2774.—p.4.

Thomas Valenti, the Vice-President of the New Jersey Prosthetic and Orthotic Society reports that the prosthetic and orthotic industry represents 0.33% of the health care industry.

Some health plans in New Jersey currently cover the benefits required by this bill and reimburse at rates in excess of Medicare. For those insurers, the cost impact may be

negative. When estimating the cost of this mandate, it was considered that some coverage for orthotics and prosthetics is currently provided. The marginal cost is the cost of providing additional appliances beyond what is covered in the current policies. Based on the marginal cost of this mandate, the increase in premiums is expected to be less than 0.025%. A study of a similar benefit in Maine estimated the cost impact to be .03% of premium based on Maine's current coverage of orthotics and prosthetics. In testimony for the support of the Massachusetts proposed legislation, the cost was estimated to be \$0.07 per member/per month (PMPM). If we assume a total PMPM cost of about \$200. This corresponds to approximately .035%.—p.6.

Potential increase in premiums from A-2774 would be less than 0.025%.—p.7.

12. Evaluation of Senate Bill 931, Joint Legislative Audit and Review Commission of Virginia's General Assembly

Thirteen percent of insurers responding to a Bureau of Insurance survey indicated they do not provide any coverage for prosthetic devices.—p. ii.

Federal Medicare laws (42 CFR ss. 414.210) state that the useful lifetime shall not be less than five years.—p.5.

The availability of prosthetic devices can improve the physical and psychological functioning of persons with amputations, injuries and congenital physical disabilities by enabling them to exercise and perform other activities of daily life. In addition, most amputees with prostheses return to some form of work and show a reduction in secondary conditions that can result from their disability.—p.7.

Amputees who have access to prosthetic devices show a reduction in the secondary conditions caused by increased sedentary lifestyle, have decreased dependence on caretakers, and a reduced chance of additional medical complications leading to further amputations.—p. 7.

Of the remaining 31 companies (who provided insurance on Virginia), 87 percent indicated that they provided some coverage for prosthetics, but that their coverage may not be equivalent to what SB 931 would require. Moreover, 13 percent of the responding insurers indicated that they do not offer any coverage of prosthetic devices.—p.10.

Individual out-of-pocket cost for obtaining a prosthetic device ranges between \$2,000 and \$30,000. Based on a median household income of \$56,859 in Virginia in 2007, this is between 3.5 and 53 percent of total household income. When considered in terms of estimated annual expenditures on health care of 5.7% of total income (\$3,241), prosthetic device costs could account for between 62% and 926% of estimated expenses.—p.13.

Mandating coverage under SB 931 is not expected to increase the number of individuals seeking care through Virginia's Medicaid program, and has the potential to reduce the number of individuals that may seek Medicaid coverage.—p.16.

Mandating coverage may reduce the overall costs of health care due to a reduction in secondary complications. Additionally, the impact on premiums charged to customers would be minimal and less than the estimated premium impact of other healthcare mandates.—p. 17.

Of the group affected by mandates, according to the BOI survey of insurers, approximately 92% have some coverage for prosthetics. However, the level of coverage varies, and it may not be equivalent to the coverage required by SB 931.—p. 18.

Other states that have reviewed similar mandates have estimated the premium impact on the consumer to be between \$0.12 and \$0.35 per premium per month. Estimates for Virginia were even lower; with per premium per month impacts between \$0.02 and \$0.08.—p. 19

This median premium estimate amounts to less than one one-hundredth of a percent of the average monthly premium for a standard single individual contract (\$214), as defined in the BOI's 2005 report on the financial impact of mandated health insurance benefits.—p.20.

The proposed mandate is not expected to have a significant impact on overall healthcare costs in Virginia and may reduce total overall costs.—p.21.

The more sedentary lifestyle (of patients without access to appropriate orthotics and prosthetics) may lead to an inability to maintain employment, an increased reliance on caretakers, an increased likelihood of experiencing depression and increased morbidity.—p.23.

Appendix B

Proposed Bill

HOUSE BILL 1612

State of Washington

62nd Legislature

2011 Regular Session

By Representatives Johnson, Green, Hope, Dickerson, Walsh, Appleton, Maxwell, Van De Wege, and Kenney

Read first time 01/27/11. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to insurance coverage of prosthetics and orthotics;
2 and adding a new section to chapter 48.43 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW
5 to read as follows:

6 (1) Each individual and group health plan that is issued or renewed
7 on or after January 1, 2012, that provides coverage for hospital or
8 medical expenses shall provide coverage for benefits for prosthetics
9 and orthotics that are at least equivalent to the coverage provided by
10 the federal medicare program, and no less favorable than the terms and
11 conditions for the medical and surgical benefits in the policy.

12 (a) "Orthotic device" means a rigid or semirigid device supporting
13 a weak or deformed leg, foot, arm, hand, back, or neck, or restricting
14 or eliminating motion in a diseased or injured leg, foot, arm, hand,
15 back, or neck.

16 (b) "Prosthetic device" means an artificial limb device or
17 appliance designed to replace in whole or in part an arm or a leg.

18 (2) Coverage required under this section includes all services and
19 supplies determined medically necessary by the treating physician to

1 restore functionality to optimal levels. The coverage includes all
2 services and supplies necessary for the effective use of a prosthetic
3 or orthotic device, including formulating its design, fabrication,
4 material and component selection, measurements, fittings, static and
5 dynamic alignments, and instructing the patient in the use of the
6 device. The coverage includes all materials and components necessary
7 to use the device.

8 (3) The reimbursement rate for prosthetic and orthotic devices must
9 be at least equivalent to that currently provided by the federal
10 medicare program and no more restrictive than other benefits in the
11 policy and must be comparable to coverage of restorative internal
12 devices without arbitrary caps or lifetime restrictions.

13 (4) The coverage must include any repair or replacement of a
14 prosthetic or orthotic device that is determined medically necessary to
15 restore or maintain the ability to complete activities of daily living
16 or essential job-related activities and that is not solely for comfort
17 or convenience.

18 (5) Prosthetic and orthotic benefits may not be subject to separate
19 financial requirements or limitations. A health plan may impose
20 copayment or coinsurance amounts on prosthetics, however financial
21 requirements may be no more restrictive than the financial requirements
22 applicable to the medical and surgical benefits, including those for
23 internal devices.

24 (6) A health plan may limit the benefits or alter the financial
25 requirements for out-of-network coverage of prosthetic and orthotic
26 devices. However, the restrictions and requirements applicable to the
27 benefits may be no more restrictive than the financial requirements
28 applicable to the out-of-network coverage for the medical and surgical
29 benefits.

30 (7) A health plan may not impose any annual or lifetime dollar
31 maximum on coverage for prosthetics other than an annual or lifetime
32 dollar maximum that applies in the aggregate to all terms and services
33 covered under the policy.

34 (8) If coverage is provided through a managed care plan, the
35 insured must have access to medically necessary clinical care and to
36 prosthetic and orthotic devices and technology from not less than two

1 distinct prosthetic and orthotic providers in the plan's provider
2 network.

--- END ---

Appendix C

RCW 18.200.010 Orthotic and Prosthetic Services Statute

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Advisory committee" means the orthotics and prosthetics advisory committee.

(2) "Department" means the department of health.

(3) "Secretary" means the secretary of health or the secretary's designee.

(4) "Orthotics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity. The practice of orthotics encompasses evaluation, treatment, and consultation. With basic observational gait and postural analysis, orthotists assess and design orthoses to maximize function and provide not only the support but the alignment necessary to either prevent or correct deformity or to improve the safety and efficiency of mobility or locomotion, or both. Orthotic practice includes providing continuing patient care in order to assess its effect on the patient's tissues and to assure proper fit and function of the orthotic device by periodic evaluation.

(5) "Orthotist" means a person licensed to practice orthotics under this chapter.

(6) "Orthosis" means a custom-fabricated, definitive brace or support that is designed for long-term use. Except for the treatment of scoliosis, orthosis does not include prefabricated or direct-formed orthotic devices, as defined in this section, or any of the following assistive technology devices: Commercially available knee orthoses used following injury or surgery; spastic muscle tone-inhibiting orthoses; upper extremity adaptive equipment; finger splints; hand splints; custom-made, leather wrist gauntlets; face masks used following burns; wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair; fabric or elastic supports; corsets; arch supports, also known as foot orthotics; low-temperature formed plastic splints; trusses; elastic hose; canes; crutches; cervical collars; dental appliances; and other similar devices as determined by the secretary, such as those commonly carried in stock by a pharmacy, department store, corset shop, or surgical supply facility. Prefabricated orthoses, also known as custom-fitted, or off-the-shelf, are devices that are manufactured as commercially available stock items for no specific patient. Direct-formed orthoses are devices formed or shaped during the molding process directly on the patient's body or body segment. Custom-fabricated orthoses, also known as custom-made orthoses, are devices designed and fabricated, in turn, from raw materials for a specific patient and require the generation of an image, form, or mold that replicates the patient's body or body segment and, in turn, involves the rectification of dimensions, contours, and volumes to achieve proper fit, comfort, and function for that specific patient.

(7) "Prosthetics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences. The practice of prosthetics also includes the generation of an image, form, or mold that replicates the patient's body or body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or cosmesis, or both. Involved in the practice of prosthetics is observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize the function, stability, and safety of the patient. The practice of prosthetics includes providing continuing

patient care in order to assess the prosthetic device's effect on the patient's tissues and to assure proper fit and function of the prosthetic device by periodic evaluation.

(8) "Prosthetist" means a person who is licensed to practice prosthetics under this chapter.

(9) "Prosthesis" means a definitive artificial limb that is alignable or articulated, or, in lower extremity applications, capable of weight bearing. Prosthesis means an artificial medical device that is not surgically implanted and that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot. The term does not include artificial eyes, ears, fingers or toes, dental appliances, ostomy products, devices such as artificial breasts, eyelashes, wigs, or other devices as determined by the secretary that do not have a significant impact on the musculoskeletal functions of the body. In the lower extremity of the body, the term prosthesis does not include prostheses required for amputations distal to and including the transmetatarsal level. In the upper extremity of the body, the term prosthesis does not include prostheses that are provided to restore function for amputations distal to and including the carpal level.

(10) "Authorized health care practitioner" means licensed physicians, physician's assistants, osteopathic physicians, chiropractors, naturopaths, podiatric physicians and surgeons, dentists, and advanced registered nurse practitioners.

[1997 c 285 § 2.]

Appendix D

Follow-Up Questions and Responses from Applicant

Prosthetics and Orthotics Mandated Benefit Sunrise Review
Department of Health Follow Up Questions to Applicant with Responses

1. (a)(ii) Was the Amputee Coalition's web poll nationwide or limited to Washington responders? When the responders had their coverage reduced or eliminated, were they maintaining the same policy with the same company or did the responders experience these reductions when changing insurance carriers?
 - The poll was nationwide and included responders from Washington. When the coverage was reduced or eliminated, they were maintaining the same policy with the same company. Some did see reductions or eliminations obviously when changing carriers as well, but the survey largely found it was the same policy.

2. (a)(iii) You address current restrictions on the benefit, but not to what extent these restrictions result in persons not receiving services. Please address.
 - The current restrictions on the benefit have a significant impact on individuals receiving the benefit. Because of the costs associated with prosthetic and custom orthotic care, the arbitrary caps that have been placed on durable medical equipment disproportionately affect individuals living with limb loss. The cost differences between crutches, canes, walkers, and wheel chairs and prosthetic care is significant. We have repeatedly heard from amputees in Washington, and across the country about the difficulty in obtaining prosthetic care because of the cost restrictions. We have experienced individuals needing to take out second mortgages, dig into retirement or college savings accounts, giving up and realizing that they cannot afford a prosthetic or custom orthotic device, and we've even had situations where people have stopped working to qualify for Medicare or Medicaid to be able to receive adequate coverage so they can return to work. The cost of prosthetics can range from very low for a below knee simple peg, to upwards of \$50,000 for a much more sophisticated above knee devices that provide an unmatched level of mobility and independence. Depending on a person's level of activity, treating physicians prescribe the most appropriate device to fit that person's need. When an active and mobile person qualifies for a more sophisticated device, but then find out they only have \$2,500 or \$5,000 in coverage, they are then required to come up with the additional costs or forego the coverage. Unfortunately this is a common occurrence and it puts an unsubstantiated burden on these policy holders.

3. (a)(iii) Is the data provided in the chart from Washington insurance providers? For comparison purposes, what are Medicare's financial restrictions, exclusions, and co-pays for prosthetic coverage?
 - The data in the chart is from insurance providers across the country, including those that operate in Washington state. Medicare does not have financial or caps or restrictions. Medicare covers prosthetic and custom orthotic devices at an 80/20 reimbursement rate. This is typically similar coverage to most state Medicaid programs. The only requirement is that if an individual falls into a certain k level, (addressed in the proposal), they are restricted to the kinds of devices that fall within the coverage for those different activity levels.

Durable Medical Equipment	
What Medicare Covers	What You Pay
<ul style="list-style-type: none"> • Air fluidized beds • Blood glucose monitors • Bone growth (or osteogenesis) stimulators* • Canes (except white canes for the blind) • Commode chairs • Crutches • Home oxygen equipment and supplies* • Hospital beds • Infusion pumps and some medicines used in them • Lymphedema pumps/pneumatic compression devices* • Nebulizers and some medicines used in them (if reasonable and necessary) • Patient lifts* • Scooters • Suction pumps • Traction equipment • Transcutaneous electronic nerve stimulators (TENS)* • Ventilators or respiratory assist devices • Walkers • Wheelchairs (manual and power) 	<p>Generally, you pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year (\$135 in 2009). Medicare pays the other 80%. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item. However, the amount you pay may vary because Medicare pays for different kinds of durable medical equipment in different ways. You may be able to rent or buy the equipment.</p>

4. (b)(ii) Is there evidence of patients who currently need these services that aren't accessing them because of the restrictions on coverage?
 - One of the most common complaints, comments, or issues the Amputee Coalition receives in our National Limb Loss Information Center, is "can you help me get a prosthetic device." The majority of the people asking this question have insurance that has a cap on it. We share with these individuals ideas and resources that might be available in their area to raise money to cover the costs. People living with limb loss have a great desire to get back their mobility and independence and they realize prosthetic and custom orthotic devices provide an unmatched level of independence and mobility. If they cannot afford the device through their insurance company, they work to figure out any way they can to get the coverage they need. Unfortunately, do to the costs that can be associated with the devices, many go without care and settle for a wheel chair or crutch. Many upper extremity amputees don't even have that luxury and if they are not able to afford it, go with nothing.

5. (a)(iv) and (b)(vi) Please provide specifics. For example, how many Washington amputees access state programs to get a prosthesis when private insurance denies coverage?
 - Unfortunately we do not have specific data to Washington state. We have seen it happen in other states, and have many members in Washington and across the

country who have participated in this. Due to the difficulty in assessing an individual's reason for relying on state programs, the exact numbers of individuals that shift from the private sector to the public sector is not known.

6. (b)(iii) and (c)(i) Is there research regarding the long-term health effects experienced by patients who lack prosthetic care?
 - There has been some research compiled by manufacturing companies, but we currently lack the independent studies that show these issues. The Colorado study for Medicaid that was commissioned by the Colorado legislature has information relating to the savings they experienced due to the coverage and the resulting reduction in secondary complications (including those mentioned in (b)(iii)) because individuals were able to access the benefit.

Post-Hearing Follow-Up Questions and Applicant Responses
August 19, 2011

Is it your intent to include foot orthotics?

- Our intention is not to include over the counter foot orthotics. Our intention in regards to orthotics is only for prescribed orthotics. We have used and would be amenable to any of the following definitions in other laws to alleviate concerns around the definition of orthotics in the Washington bill:
 - **Oregon** – 'Orthotic device' means a rigid or semi rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck
 - **Rhode Island** – "Orthotics" means the science and practice of evaluating measuring, designing, fabricating, assembling, fitting, adjusting or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury or deformity
 - **Indiana** – "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.
 - **Arkansas** – "Orthotic device" means an external device that is: (i) Intended to restore physiological function or cosmesis to a patient; and Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient. (B) "Orthotic device" does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: (i) Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body

Please provide some specific examples of Washington companies that restrict access to care, including the names of the carriers and what types of restrictions they include in their plans.

Below are some examples we've found to be in place in some Washington insurance plans unfortunately with the time frame I'm unable to look at every plan in Washington, however this provides some current examples of coverage, ranging from no coverage at all, arbitrary caps, up to the 80/20 reimbursement rate called for in the bill:

- Lifewise – Individual – Wise Simplicity – DME & Prosthetics – not covered
- Lifewise – Individual – Wise Essentials Rx – DME & Prosthetics – not covered
- Lifewise – Individual Wise Essentials Copay – DME & Prosthetics – not covered
- Lifewise – Individual Wise HSA – DME & Prosthetics – 80/20 after deductible

- Lifewise – Wise Choices Prime – DME & Prosthetics – 70/30 after deductible
- Lifewise – Large Group 51+ - unlimited; non-diabetic orthotics maximum \$300 per calendar year
- Premera – Heritage Value Plus 30 – 70/30 with \$5,000 max per calendar year
- Premera – Heritage Preferred Plus 30 – 70/30 with \$5,000 max per calendar year
- Premera – Heritage Preferred Plus 20 – 80/20 with \$5,000 max per calendar year
- Premera – Heritage Protection Plus 20 – 80/20
- Regence – small group – maximum benefit of \$20,000 per calendar year
- Asuris Northwest Health – varying plans, 80/20 after deductible, 70/30 after deductible, or 50/50 after deductible
- Regence BCBS – varying plans, 80/20 after deductible, 70/30 after deductible, or 50/50 after deductible
- Group Health Cooperative – Individual plans: Welcome 750 plan, Balance 1250 plan, Balance 1750 plan: 50% up to \$40,000 in charges (\$20,000 max. benefit per calendar year)
- Group Health Cooperative – Balance 2000 plan, Balance 2500 plan, Balance 5000 plan, Welcome 1850 plan, Welcome 3500 plan: 50/50 after deductible
- Group Health Cooperative – Small Group – Maximum benefit of \$32,000 paid (80% of \$40,000)
- United Health Care – PEAT Association Plan – maximum benefit of \$5,000 per calendar year

Do the mandates in the other states you cite in your applicant report include orthotics? If so, do they include foot orthotics?

- Ten of the laws (California, Oregon, New Jersey, Rhode Island, Indiana, Arkansas, Texas, Illinois, Utah, and Delaware) include language regarding benefits for orthotics. Maryland includes coverage for “orthopedic braces.”
- None of these laws include coverage for foot orthotics, nor is that our intent.

Is it your intent that the prescribing physician would determine medical necessity, with no ability for carriers to use their internal utilization review processes?

- No. The carriers would still be able to use their internal utilization review processes, although the medical necessity would be determined by the treating physician, carriers would still be able to review to ensure the prescribed device is the most adequate device to restore the individual’s functionality to optimal levels.

Appendix E

Public Hearing Summary and Participant List

Prosthetics and Orthotics Mandated Benefit Review
Public Hearing Summary
August 9, 2011

Kristi Weeks called the meeting to order at 9:10 A.M.

Ms. Weeks introduced herself. She is the Director of Legal Services and also the legislative liaison for Health Systems Quality Assurance. She introduced Sherry Thomas as the sunrise review coordinator.

She then introduced the panel members, Judy Haenke, a program manager within the Health Systems Quality Assurance Division at the Department of Health; Jeff Wise, policy and planning coordinator with the immunizations program; and Mike Weisman, a staff attorney within Health Systems Quality Assurance Division. She also introduced Patty Stuart, who is the staff attorney at Department of Health who is writing the initial draft of the report.

Ms. Weeks then gave the instructions for hearing, and provided next steps for after the hearing. She stated that there will be a ten-day written comment period for interested parties to provide additional information for topics brought up at the hearing, to clarify things said, etc., and for those who could not attend in person to submit information. Submit comments to the Department of Health at P.O. Box 47850, Olympia, 98504-7850. She stated that comments can also be submitted by email to "SUNRISE@ DOH.WA.GOV."

The applicant's report will be presented by Roman Daniels-Brown. The panel members will ask questions during the presentation, which will be followed by public testimony.

Roman Daniels-Brown

Mr. Daniels-Brown introduced himself as representing the Amputee Coalition of America. He stated that Dan Ignaszewski, Government Relations Coordinator of the Coalition, asked him to provide remarks on his behalf since he could not attend the hearing. He offered to follow up on any questions he cannot answer at the hearing.

Mr. Daniels-Brown provided background on the Amputee Coalition. He stated that it is the only national nonprofit organization, and serves over two million people with limb loss and 28 million people at risk for amputation across the country. The Coalition is celebrating its 25th anniversary this year, and represents amputees of all ages living with the loss of or absence of limbs. The Coalition has constituents, industry partners, peer visitors and support groups throughout the state of Washington and around the country. Mr. Daniels-Brown stated that according to the health care cost and utilization project state and patient databases, the prevalence of amputations in Washington state in 2009 was 2,249, with 27,065 amputations between 1997 and 2009. This is an average of 2,055 amputations per year. These figures do not account for the limb loss population prior to 1997 and the figure might be slightly higher, however it is the most accurate data available.

Mr. Daniels-Brown stated that House Bill 1612 is an important bill for the limb loss community, and is about access to restorative care. The Colorado study submitted with the proposal shows that by requiring their state Medicaid program to cover prosthetic and custom orthotic devices, the state saved money. He stated this is because of the restorative nature of the devices, which provide an unmatched level of mobility and independence and drastically reduce secondary complications from sedentary lifestyles. He stated that this type of limb restoration is needed to

resume life in a normal way. Restorative prosthetics and orthotics are the difference between being able to walk or being wheelchair bound, working or not, and being able to conduct activities of daily living.

He stated that prosthetics and orthotics are prescribed by physicians based on clear guidelines for medical necessity (that are also laid out in the proposal). These guidelines require doctors to take into account:

- An individual's functional ability;
- Rehabilitative expectations of the patient;
- Physical condition of the residual limb;
- Other issues such as vascular or arthritic problems;
- Lifestyle factors, including employment and activity levels;
- Independent living status;
- Timeframe for recovery; and
- Access to care.

Mr. Daniels-Brown stated that unlike other devices in the durable medical equipment category, (crutches, wheelchairs, and walkers) prosthetic devices provide an unmatched level of independence and restorative mobility. Prosthetic devices are the only tool that comes close to restoring functionality for people with limb loss.

He stated that the Veteran's Administration, Medicare, Medicaid, and other state rehabilitation programs have been covering prosthetics at appropriate levels for years. Yet insurance companies are setting caps and restrictions, with the most common caps nationally being \$2,500 or \$5,000 per year. There are also instances of insurance companies only providing one limb per lifetime. This is unimaginable for an amputee who has lost a limb in a car accident or for a child born with a limb difference. This child will need to have new prosthetics fitted as they grow. Mr. Daniels-Brown stated that Amputee Coalition members have told stories of being forced to stop working so they could become eligible for state and federal programs that allowed them to get needed prosthetic care. They could then return to being active and contributing members of society.

He stated that exact numbers and instances of this shift from the private to the public sector are unknown. However, he stated the Coalition has heard about it directly from constituents, who have paid premiums through a private insurer in order to provide necessary health care in cases of catastrophic health needs. He stated that the insurance industry is often concerned that coverage of prosthetics and custom orthotic devices will vastly increase costs. However, the 19 states that have passed laws have not shown this as true. He stated that these concerns never take into account costs of covering secondary complications that occur when the primary needs are not properly met.

Mr. Daniels-Brown stated that House Bill 1612 allows physicians and prosthetists to prescribe the most appropriate device for an individual's needs based on medical necessity to restore an amputee's functionality so they can reach their full potential. Delaware will soon become the 20th state to pass a similar law to 1612. This has become a national effort as more states push for this legislation.

He stated that several of the states that passed prosthetic and orthotic laws also conducted state-sponsored independent cost studies on the effect of covering prosthetics. These legislatively required studies consistently found that costs of coverage would be low. He stated that on average, premiums rose by only \$.12 per member per month. Some of these studies found that not covering prosthetic and orthotic services can cost more money in the long run because of secondary complications from a sedentary lifestyle. By providing access to

appropriate care when a prosthetic or orthotic device is determined to be the most appropriate, amputees are able to remain active, employed members of our community.

Mr. Daniels-Brown also stated that health insurers have been saying that if this bill passes, everyone will get the most expensive computerized prosthetic device, or everyone will have to cover over-the-counter foot orthotics. He said this has not been shown true in the states that have passed similar laws. Physicians are bound by what can and cannot be prescribed to individuals. Like joint replacements or broken bones, this is a medical decision between a doctor and patient. This bill does not provide coverage of over-the-counter foot orthotics, but allows people with debilitating issues to get custom orthotics that would improve their mobility and independence. Individuals who do not receive an appropriate prosthetic or custom orthotic device may be subject to a wheelchair, which would increase secondary risk by not being able to be as mobile and active. Individuals may need additional income such as social security or disability benefits because of the added cost of being unable to get around independently.

He stated that there may be instances where this lack of mobility and independence is so great that in-home help is needed or a person must leave their current living situation. Individuals who do not get adequate care often need to be retrained to find different career paths. This impacts both the individuals and the businesses that lose valued employees. These added costs to the state, insurance companies, and the individuals and their families are not specifically known. However, he stated that comments and questions to the Amputee Coalition's national limb loss information center show they exist.

Mr. Daniels-Brown reiterated that the reason insurance companies exist is to cover individuals in the case of catastrophic illness or injury. Insurance covers when someone breaks a bone in their leg, or needs an internal device such as shoulder or elbow replacement. External prosthetic devices are just as essential to an amputee as a hip joint is to someone with debilitating arthritis and should be treated the same way.

Mr. Daniels-Brown stated that the reason insurance companies exist is to cover individuals in the case of catastrophic illness or injury. Insurance covers when someone breaks a bone in their leg, insurance companies cover the care to get the person back on their feet. When someone has a shoulder or elbow replacement so they can use their arm again, insurance companies cover these internal devices. External prosthetic devices are just as essential to an amputee as a hip joint is to someone with debilitating arthritis and should be treated the same way.

He stated the bill will allow doctors to treat prosthetic devices like these and other restorative benefits within an insurance policy. It would require coverage to be equal to what the federal government covers through Medicare, and what most state Medicaid programs cover with a 80/20 reimbursement rate on these devices. People expect to be covered by their insurance in the event of a catastrophic illness or injury. The loss or absence of an arm or leg would qualify.

This legislation requires that prostheses are treated the same as other basic, essential care. By not adequately covering prosthetic devices for individuals who need them, they are not given the chance to reach their full potential, and are subject to costly secondary complications.

He stated that they encourage us to take this opportunity to ensure individuals with limb loss or limb difference are given the access to care they need to remain contributing members of society, instead of dependent upon it. Arms and legs are not luxury items and should not be as such.

Questions from Panel

Jeff Wise

Mr. Wise stated that he noticed in the original information submitted by the applicant, it was mentioned several times that people will often end up on Medicare to get coverage for these devices. In some follow up questions, they said they don't have numbers on this. Is there any way to quantify the degree to which this is happening?

Applicant Response

Mr. Daniels-Brown stated that they have some personal examples, and he thinks the executive director of WOPA is going to share one. He said he doesn't know if they can quantify it for patients in this state. Maybe the providers who perform those services have a better idea where they are billing out. ACA does not have specific numbers on that, but he thinks they found cost savings in the Colorado study.

Jeff Wise

He stated that in the 19 or 20 states that have done similar things, the studies show \$.12 or \$.42, depending on where you are. Looking back at the fiscal note done by the Health Care Authority, they estimated about a 1% increase on premiums. He asked whether the applicants have any comment on that.

Applicant Response

He stated that he spoke to the HCA, and he thinks the sunrise review might be able to unveil the more correct number. He stated that a fiscal note is done during session quickly and he thinks the HCA's is based on some information they received from insurance companies on short notice. They were certainly doing their best. He stated he is sure they would agree with what comes out of the sunrise review.

Mike Weisman

Mr. Weisman stated that the information provided by the Amputee Coalition primarily focuses on prosthetics for amputees. He asked whether that includes devices that would be less than a replacement for arm and leg, for example, braces, or other kinds of devices that would fit on an arm and a leg or part of the body that has been injured or damaged and requires support.

Applicant Response

The applicant stated he will let the providers talk specifically on what they provide to individuals. He said it is the custom orthotic devices, as well as a leg replacement or prosthetic that they would be prescribing. On technical equipment, he stated he will defer to his friends in the audience.

Mike Weisman

He asked whether it is the applicant's understanding that those devices would fit under the definition of the mandated benefit.

Applicant Response

He stated he believes so.

Mike Weisman

He stated that some orthotics, specifically foot orthotics, are provided by podiatrists, while some are not. Some are provided by independent practitioners. He stated he doesn't see anyone addressing the issue of orthotics provided by the prescriber or even prosthetics provided by the prescriber.

Applicant Response

He stated he thinks there was some uncertainty about foot orthotics in the legislation, as to what was and was not included. When the chair of the committee, Representative Cody, submitted her request, she specified that she wants to make sure foot orthotics are specifically excluded. He stated they would concur with her on that and they need to make sure the language is clear that those specific foot orthotics are excluded.

Mike Weisman

He stated that he didn't see foot orthotics excluded in the text of the bill.

Applicant Response

He stated that they had talked to the chair of the committee, asking her that foot orthotics be excluded moving forward because it is not addressed in the current bill. They wanted the sunrise review to look at it with foot orthotics excluded, with the intention that Chair Cody and other members were going to make that exclusion very clear with an amendment.

Mike Weisman

He stated that it is his understanding that the mandate does currently include foot orthotics, and asked whether he is reading this wrong.

Applicant Response

He stated that some people don't believe it does. Others believe it is excluded. There is argument on both sides.

Mike Weisman

So, there is some uncertainty about this?

Applicant Response

He stated that there is uncertainty about whether foot orthotics are included in this, which is why they are looking for specifying language to make it very clear that foot orthotics would not be included.

Kristi Weeks

Ms. Weeks stated that she thinks some of the confusion is that the department is asked to review a specific bill, and must review the language in the bill. She stated that in the past, the department has had situations where, by the time the review is complete, the bill has changed three or four times. But the department must review the bill provided.

Applicant Response

The applicant referred back to conversations with Representative Cody on this issue.

Mike Weisman

Mr. Weisman stated he is not privy to back room conversations. He must look at what he's got in front of him, which seems to include foot orthotics as it is written now.

Applicant Response

He stated he would submit for the record, if the department doesn't have a copy of the request from Chair Cody for the sunrise review, that we get one. He stated he can make sure the committee has that, where she states that the bill going forward is intended to make a clear exclusion of foot orthotics.

Mike Weisman

Mr. Weisman asked whether Chair Cody is contemplating some changes when the legislature comes back.

Applicant Response

The applicant stated this is correct, but they don't have the ability right now to change the bill. He stated the proponents are in favor of including that exclusion.

Mike Weisman

He clarified that Mr. Daniels-Brown is representing the applicant.

Applicant Response

Yes.

Mike Weisman

He stated that as far as he can tell, in some of the ways in which insurance companies were writing their coverage, they were limiting replacement or repair of devices on an annual basis. He asked whether the applicant is advocating that not be limited.

Applicant Response

He replied that they are advocating it be aligned with what Medicare provides right now, and the state Medicaid programs provide adequate coverage as well. He said they think doing so will get rid of those instances where individuals are in a financial strap and have to leave employment and leave insurance so they can go onto the state program to get the prosthetic they need that is too costly for them to get otherwise.

Mike Weisman

He had a question about that specifically, and the impact of tying this to the Medicare reimbursement rate would have on the market place. It is possible that the Medicare reimbursement rate may be less than what some practitioners charge patients for their out-of-pocket payments. In his experience, he stated that's generally the case. Despite what might be in the news, Medicare reimbursement rates are generally less than what is the counter price of the device.

Applicant Response

He stated, he thinks this is correct.

Mike Weisman

It expands the potential market, of course.

Applicant Response

He stated this is correct, and they are fully aware that in some instances they would potentially lose income on that.

Mike Weisman

Mr. Weisman stated, but be able to treat more patients.

Judy Haenke

Ms. Haenke asked about his testimony around custom orthotic devices, stating that's not what is defined in the bill. There are a lot of different orthotic devices that would meet that definition.

Applicant Response

He said he will defer to Sanjay Perti, who will testify later, on the different types of technology.

Judy Haenke

She asked about paragraph eight when it talks about a managed care plan, and states that an insured must have access to medically necessary clinical care from not less than two distinct prosthetic and orthotic providers. She asked him to expand on that.

Applicant Response

He also deferred this question to Sanjay Perti.

Jeff Wise

Mr. Wise had one follow up question. He stated that some of the major concerns he has seen, and that the applicant touched on, were the definition of orthotics, and the medical necessity piece. In some interpretations of the language in the bill, there was concern about there not being the ability for any kind of review. If the treating physician orders it, then it is covered. This was not the same as other benefits covered in any other insurance policy. He stated he has not read the bills from the other states, but in similar instances in these areas, the testimony was that it did not increase any substantial amount of high end or what might be unnecessary use. He asked whether there has been any discussion along the same lines about further medical review of medical necessity than what the physician has prescribed.

Applicant Response

He stated he thinks there is some language in the bill, and he thinks medically necessary has meaning as to what they are providing on that. He stated he will talk to Dan (Ignaszewski) about this and get a better response.

Mike Weisman

He stated that he thinks part of the question is, medically necessary from the initial prescriber, who determinates what the need is. He said that's the person who is determining that a device, prosthetic or orthotic, is medically necessary. But he said there are comments from the HCA, for example, and they call it a medical necessity review, but it's their secondary review, which is often called a utilization review or something like that. He said that is their second look at the medical necessity determination made by the person's physician. It's generally an internal process.

Applicant Response

Sometimes they are combined a bit and it goes pretty quickly.

Mike Weisman

He said that sometimes it goes pretty quickly, but it depends what it is. Sometimes it can take a long time and be quite arduous

Applicant Response

He will ask Dan Ignaszewski at ACA how they have dealt with medical necessity in other states

Jeff Wise

Mr. Wise stated he thinks the concern the HCA was getting at was, does the language in the bill preclude additional review, or does it mean that once a physician prescribes it there would not be any further review for medical necessity.

Applicant Response

He said he doesn't think it precludes additional review. He is not sure if the insurance carriers could require additional review as part of their package or not. Maybe the plans would state that they cover it, but need one review done, or something to that effect

Mike Weisman

He stated he doesn't see anything in the legislation that says they cannot conduct their own internal review.

Sanjay Perti

Mr. Perti introduced himself as President of the Washington Prosthetic and Orthotic Association. He is a Washington State licensed and certified prosthetist and orthotist who graduated from the University of Washington, School of Rehabilitation Medicine. He completed two years of residency to achieve his title, followed by four exams to become certified and licensed. Prosthetists and orthotists evaluate, treat and provide appropriate prosthetic devices to patients under physician prescriptions. A prosthetic device replaces a missing body part and an orthotic device supports a weakened or deformed body part. Mr. Perti stated this bill will allow for appropriate prescribed medical treatment to occur and not be subject to unreasonable exclusions and limitations.

He stated that currently, prosthetics and orthotics are categorized by Medicare and many insurance companies together as DMEPOS durable medical equipment prosthetic/orthotic supplies. This also includes crutches, canes, wheelchairs and diapers, which orthotists and prosthetists don't provide. He stated this bill helps to differentiate them and the custom devices they provide, from the durable medical equipment category. He stated that these devices are carefully designed and custom fit to help patients return to their normal activities. The costs of these devices include evaluation, casting, fabrication, fitting, instruction and follow up.

Mr. Perti stated that some private insurance policies feature exclusions, yearly maximums of \$500 and lifetime maximums of one prosthesis. Medicare does not set maximum amounts on prosthetic/orthotic coverage and will cover devices at 80/20 rate. He stated this bill would require coverage at a similar level. While his field encompasses many non-custom orthotic devices, the main focus is toward those that are affected by unreasonably low caps and maximums. Because of these caps, Mr. Perti stated he see patients struggling or unable to receive a device, such as a trans-tibial prosthesis (below-knee) or a trans-femoral (above-knee) prosthesis due to the financial burden.

Mr. Perti stated that costs vary due to the variety of devices they provide. The average cost of a prosthesis is \$12,000 and costs can range widely depending on the level of amputation and an individual's functional level. When someone has an insurance plan limit of \$5,000, which is not uncommon, they are left with the majority of the financial burden.

Mr. Perti provided some examples. One example was from his colleague, who was treating a female patient in need of a new prosthesis. She had no coverage under her current private insurance through her employer. In order to obtain a prosthesis, she was forced to quit work and eventually was covered by Medicaid. She was then able to obtain an appropriate prosthesis so she could return to work. This shifted the costs to the state and the tax payers.

Mr. Perti provided another example of a 16 year old gymnast with an overuse stress fracture on her lumbar spine. He stated that appropriate treatment, prescribed by her orthopedic surgeon, was to wear a custom lumbar back brace for three months. The patient's insurance had a \$500 limit, and for a single parent, this was a significant financial burden on someone who thought they had good coverage. This same coverage would have covered surgery, though that would not have been the appropriate treatment. A physician would not want to do this surgery on an adolescent when the brace could completely take care of her condition.

Mr. Perti stated that the main purpose of this bill is for reasonable prosthetic and orthotic coverage equal to the levels the federal government provides under Medicare. He stated it is

the job of prosthetists/orthotists to ensure their patients receive the most appropriate prescribed orthotic and prosthetic treatment. It is the intent of this bill to help them obtain appropriate care.

Mr. Perti then responded to a couple of questions brought up earlier.

He stated that the definition of orthotics are any that are going to treat a weakened or deformed body part, so anything from the neck, back, to the legs. Under a true definition, orthotics also includes foot orthotics. He stated their goal, as well as the goal of the bills that have gone through in other states is that they are tied to the Medicare benefit. He stated that Medicare provides for zero foot orthotic coverage, and that custom, off the shelf products are not covered. That's really where they want this tied is to the Medicare benefit, not including custom foot orthotics.

The other question he addressed was regarding reimbursement. He stated that he doesn't think this bill actually touches on reimbursement levels at all. He stated that in his field, most of the insurance contracts fall under Medicare level, which he does not feel this bill addresses.

Mike Weisman

He had a question on the last answer provided on reimbursement. If a patient is a Medicare patient, once Medicare is billed and paid, the provider cannot go back to the patient to make up any difference

Sanjay Perti

That may or may not be true.

Mike Weisman

Unless there is a Medicare defined co-pay.

Sanjay Perti

He stated it can actually be more than that in his field. He stated they can choose to accept Medicare assignment on a case-by-case basis or they can sign up to accept it every time. He said they have in their field some discretion to accept Medicare assignment or not, and they can choose to bill at a higher rate. Medicare directly pays the patient that money and then they are responsible for paying the providers. He said that rarely occurs.

Mike Weisman

Is that because you are a DME provider?

Sanjay Perti

Yes. He stated that is their rule.

Mike Weisman

Because you are a direct service provider?

Sanjay Perti

He stated that he thinks that is the case. He said they usually accept Medicare assignments. However, there are instances where their costs of purchasing a product like a lumbosacral corset, costs more just to order it from the manufacturer than they are reimbursed by the insurance companies. In an instance like that, he states they have to consider time to see the patient, fit, and follow up, liability, billing, and the time to collect the payment. And they may choose not to accept a rate that is much below what they pay for an item. He says you can't be in business doing that.

Mike Weisman

He stated he understands, but part of the reason we use these Medicare as a benchmark is because they go out and do all the research across the country on what rates are reasonable. They do that homework so we can take their number as a benchmark. But if someone bills their insurer or Medicare directly or the patient files a claim, that may give them some financial relief, but then there is no limit to what the patient is charged for the device, and it could be quite a bit different from provider to provider.

Sanjay Perti

He stated he doesn't think this bill addresses reimbursement at all. It will not address Medicare at all since that's at a federal level.

Mike Weisman

No it just uses that as a benchmark.

Sanjay Perti

He said he honestly wishes it did control reimbursement in relation to Medicare, but in his understanding of the bill, it doesn't even speak about reimbursement or affect it. He said they can either choose to accept a contract or lose the business. Sometimes there are out-of-network benefits, which create a huge burden for the patient, who is all of a sudden covered at 50%. A patient can't afford that and will usually end up choosing a different provider.

Mike Weisman

He asked whether they are contemplating a situation where a patient might have mandated benefits (if a recommendation goes through and eventually policy holders all over the state have this mandated benefit) but they might go to the prosthetic provider in their community and be told they are not accepting that benefit because the reimbursement rate (or payment rate) is too low, like you just described.

Sanjay Perti

That could potentially happen. There is that language about more than one provider in a geographic area, because certain insurance groups have signed contracts with large groups.

Mike Weisman

He clarified that it said two providers in the network, so that could be the entire state.

Sanjay Perti

It's a very loose definition. He said they are just trying to address these problems with the caps and maximums. The ACA had a great poster for this at a federal level. He stated that the poster said to grab one leg and put it behind your back and hop. This is what occurs if you don't have a leg. He stated they are not trying to address everything in this bill. It won't even impact every person in Washington. There are out-of-state insurance plans, etc., so he thinks that at best it will impact 40-60% of people in the state. It's a start. It really has to go through at a federal level to affect everyone, and he said they are hoping that occurs. But he said he hopes it will affect some people.

Melissa Johnson

Ms. Johnson introduced herself as representing the Physical Therapy Association of Washington. She said they testified on HB 1612 during the 2011 session because physical therapists have the authority in their scope of practice to treat patients in the prosthetic and orthotic field. RCW 18.74.010(c) defines part of the physical therapy scope as "training for, and the evaluation of, the function of a patient wearing an orthosis or prosthesis." She stated they feel they have a vested interest in this legislation, and they asked during their testimony last session that physical therapists are included because of their scope of practice.

It is often the treating physician who refers to a physical therapist for further training and function on movement of the patient wearing a prosthesis or orthotic. They feel that since the legislation only talks about the treating physician, and what he or she is doing, it leaves out part of the very necessary treatment of the patient if that person is referred to a physical therapist. She stated they asked during the legislative hearing to add treatment by physical therapists so the full access to care of a patient that needs a prosthetic or orthotic can be included in the coverage and not stop at what the treating physician is prescribing. She said that is their testimony consistent with what they said during the 2011 session. With that change, she said they would very much support this mandated benefit.

Kristi Weeks

She asked whether they would support the mandate without the additional language.

Melissa Johnson

She stated they would likely be neutral.

Mark Gjurasic

He introduced himself as representing the Washington Occupational Therapy Association. He stated he had very similar comments to those of the previous speaker. He said that on February 14, they testified before the committee on House Bill 1612 and they want similar language as was just stated. He said they support this legislation and hope the recommendation includes their additional language.

He said they understand that House Bill 1612 requires health plans to provide coverage for benefits for prosthetics at least equivalent to the coverage provided by the federal Medicare program. He stated that Medicare law specifies that payment for the custom fabricated orthotics and prosthetics are furnished only by qualified providers, including occupational therapists and the citation under 42 USC is stated in his testimony.

Occupational therapists are licensed in Washington state under 18.59.020. This is the definition section, which specifies that occupational therapist services include designing, fabricating, or applying selected orthotic or prosthetic devices. The language he said they would recommend included in any future legislation includes the second paragraph in his testimony. It does say, including orthotic devices and services provided by a licensed occupational therapist as defined in RCW 18.59.020(2). He stated he wants to make sure their scope of services is maintained and should be clarified in future legislation. He said if this bill had gone forward without going through sunrise, they would have requested an amendment with probably this exact language. He stated he recommends the department look at this closely and include the language provided.

Mike Weisman

The scope is defined as designing, fabricating, or applying. He asked whether Mr. Gjurasic finds that different from prescribing, and if so, what those words mean.

Mark Gjurasic

He stated that he wished he had a provider here because he knew that question would come up. He will need to get clarification for on that and submit it within the ten days for additional comments.

Mike Weisman

He said he understands the scope issues, but this is not clear to him. The scope is defined in law and he wondered how the scope of physical therapists and occupational therapists interweave with physicians and podiatrists. It's not quite clear.

Mark Gjurasic

He said he will get an answer.

Panel members indicated surprise that the podiatrists did not send someone to testify at the hearing.

Kristi Weeks

Ms. Weeks asked for one of the applicant representatives to come back up to the podium because she had a few follow up questions. She stated that there are many professions that touch on the prosthetic and orthotic devices, mainly orthotics. She asked how they feel about including other professions, such as PT and OT, and if so, what other professions should be included. She stated that we wouldn't want to leave a profession out just because they didn't show up at the hearing.

Sanjay Perti

He responded that under state law, whoever is a provider for an applicable device should be allowed to provide that device. There is a lot of overlap in his field. Occupational therapists do a lot of custom hand splinting. Physical therapists do a lot of off-the-shelf bracing, so there is that overlap. Those items usually don't rise to the costs where we are hitting lifetime maximums, \$5,000 per year benefits. They are usually fairly smaller costs. While they definitely should not be excluded, he said he doesn't think that's the main thrust of this bill, those smaller cost items. It will affect them, like in cases where they reach a cap, this would eliminate those caps, which may affect a physical therapist or an occupational therapist. He said he thinks that is fine because they all work well together, and they have their specialties and he has his, and there definitely is overlap. Licensure law and scope of practice for OTs and PTs and prosthetists/orthotists have already defined those.

Kristi Weeks

Ms. Weeks asked whether Mr. Perti knows any other professions that should be included.

Mr. Perti replied that podiatrists are mainly foot orthotics. Since this bill excludes foot orthotics, he did not think so. Otherwise, these are the three. For an off-the-shelf orthotic, you don't have to be a certified orthotists, prosthetist, OT or PT. That's not covered under any licensure. There are durable medical equipment companies that would also be able to bill out such devices under this law too.

Kristi Weeks stated that the bill talks about supplies and services and asked him to address services. For example, what if the prosthetist creates the leg and then sends the patient to a physical therapist to increase the muscle tone in the upper leg. That's a service, not a supply. It's related to the prosthesis. Would that be covered?

Sanjay Perti

He replied that it is his understanding is that this is about devices.

Kristi Weeks

Ms. Weeks stated that's not what the bill says. It says all services and supplies determined medically necessary.

Sanjay Perti

He replied that he doesn't know. The ACA drafted this bill, but it was his understanding that it was about the device. He said there are services provided in an L-code which is a billing code that provides for evaluation, casting, fitting, follow up, and instructions. He said those are all lumped in. If a physical therapist or occupational therapist bills under an L-code, they would

also have to include all of this, because otherwise it would be double billing. Under an L-Code, which is an orthosis or prosthesis as defined by Medicare, all of those are included. Therapy services are totally separate.

Kristi Weeks

She clarified that he is stating this is not meant to apply to therapy services that are not directly related to providing the device.

Mr. Perti

He stated that is correct. To quote the bill, he said that coverage includes all services and supplies. He said that the term, services, is not meant to include therapy. This is not meant as a device bill. It is not meant to go beyond that scope.

Kathy Gano

She introduced herself as representing Premera Blue Cross, which was the only carrier at the hearing. She stated she was sure the rest of the carriers had submitted written comment, as well as the AWHP, which is their association of insurance providers.

She stated that Premera had already submitted written comments and she was just going to highlight some of their concerns. They are opposed to the mandate for several reasons. Premera and a majority of health plans already provide options for consumers for prosthetic and orthotic coverage. The majority of Premera's plans have no lifetime limits for prosthetics. Most plans do not have an annual maximum. Cost-sharing is similar to medical benefits with a deductible and then 20-30% coinsurance, depending on the specific plan.

She stated they are urging the Department of Health to see what the Department of Health and Human Services (HHS) includes as essential health benefits that must be covered. One of the categories is rehabilitative and habilitative service and devices. They expect prosthetics to be addressed as part of this. They are concerned about the medical necessity language in the proposal, which would require all services determined medically necessary by the treating provider to be covered. Carriers typically perform medical management to review services and devices to determine whether medically necessary and appropriate, not necessarily the physician. Removal of this function will result in increased costs and can impact patient safety and care. She stated that even CMS has a process in place to review items and services as reasonable and necessary before Medicare pays for such items or services.

Consumers should have access to coverage for these things, and Premera currently provides options for consumers, most without lifetime or annual limits.

Sanjay Perti

He came back up and added that the question came up earlier regarding how often he sees these caps. He stated that most of the time he doesn't see the caps. He said he doesn't usually see them in the federal government and state insurance programs. He says where he typically sees the caps are with individuals trying to purchase their own plans and smaller businesses. He stated the medium and larger corporations usually have the best coverage. There are some plans that are only available to the smaller groups. The smaller plans aren't looking for prostheses when choosing their plans and all of a sudden, they have an employee who is impacted by this, creating a big hardship. What can that company do, change insurance carriers for one employee? He said it is not a majority of the plans. It's a small percentage, but that has a huge impact on their employees.

Judy Haenke

She added another question. On the prostheses, it says optimal level. What does Medicare cover?

Sanjay Perti

He responded that for lower extremity, Medicare has functional levels, and he believes the information from Dan at the ACA includes those. That is what Medicare uses, as well as private insurers. There is a check and balance where if a person reaches a certain level, they can have a device for that activity. For example someone who is a K-4, is a high impact, usually a young kid, running, jumping. He stated he would fall into a K-3 category. He can walk various terrain, slopes and hills at various speeds, fast, slow, and still occasionally run. Then he mentioned a community ambulator, one speed walker. Beyond that, he said there is a minimal walker, who can only walk ten feet. When he is putting together a prosthesis from a physician prescription, this K-level plays into what components, what parts of the prosthesis, will be specific to these functional levels. He stated you shouldn't see somebody sitting in a wheelchair with a running foot. There are those guidelines in place and private insurances currently use them. So that is really already set by Medicare and others.

Kristi Weeks then wrapped up the hearing and gave next steps.

- There is an additional 10-day written comment period starting today through August 19 at 5:00 for anything you feel has not been addressed.
- We will share an initial draft report with interested parties by early September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- We will incorporate rebuttal comments into the report and submit it to the Secretary of the department for approval in October.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the Governor, legislature, and state agencies.

Ms. Weeks closed the hearing at 10:10 A.M.

Hearing Participants

Roman Daniels-Brown	Amputee Coalition of American	Pro
Melissa Johnson	Physical Therapy Association of Washington	Pro
Sanjay Perti	Washington Prosthetic and Orthotic Association	Pro
Mark Gjurasic	Washington Occupational Therapist Association	Pro
Kathy Gano	Premera	Con

Appendix F

Written Comments



Physical Therapy Association of Washington
208 Rogers St NW, Olympia WA 98502-4952

360 352-7290 · telephone
800 554-5569

360 352-7298 · facsimile
<http://www.ptwa.org>

A Chapter of the American Physical Therapy Association

August 2, 2011

Sherry Thomas
Department of Health
PO Box 47850
Olympia, WA 98504-7850

Via email: sunrise@doh.wa.gov

Dear Ms. Thomas:

On behalf of the Physical Therapy Association of Washington (PTWA), I am providing our comments on the mandated benefit sunrise review of coverage for prosthetics and orthotics. PTWA supports HB 1612 and urges the Department of Health to issue a positive sunrise review decision that mandates insurance coverage of prosthetics and orthotics at a level at least equivalent to the coverage provided by Medicare. In addition, as PTWA testified during the legislative hearing on HB 1612, we request that coverage under the legislation be expanded to include all treatment, services, and supplies given by a licensed physical therapist.

Physical therapists are educated and trained in examining and evaluating individuals with functional limitations in movement, including the treatment of patients with an orthotic or prosthetic. RCW 18.74.010(c) defines the physical therapy scope of practice as including "training for, and the evaluation of the function of a patient wearing an orthosis or prosthesis..." Often it is the treating physician that refers a patient to a physical therapist for further evaluation of the patient's movement and function with an orthotic or prosthetic. Thus, it is the physical therapist that is making the evaluation and treating the patient, not the treating physician.

HB 1612 only requires coverage for "all services and supplies determined medically necessary by the treating physician to restore functionality to optimal levels." Absent language allowing for coverage for all treatment, services, and supplies given by a physical therapist, much of the patient's treatment will remain uncovered by his or her insurance plan. Therefore, to ensure adequate coverage for all of the patient's care, treatment by a physical therapist should be included in the insurance coverage mandate.

Thank you for the opportunity to comment on the sunrise review for coverage of prosthetics and orthotics.

Sincerely,

Susan Chalcraft, PT, MS
President



Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association

August 2, 2011

VIA E-MAIL AND U.S. MAIL

Washington State Department of Health
Sunrise Review
ATTN: Sherry Thomas
PO Box 47850
Olympia, WA 98504

Re: Prosthetics & Orthotics Parity Mandate Sunrise Review

Dear Secretary Selecky:

Thank you for the opportunity to provide comments to the Sunrise Review for parity in insurance coverage of prosthetics and orthotics as envisioned in 2011 House Bill 1612. Regence BlueShield feels this is a timely topic and important discussion given the increased focus on health care cost in the newly reformed system. In that light, we respectfully submit the following comments for your consideration.

Regence provides coverage of prosthetics and orthotics on all group products at regular plan levels (deductibles and/or co-insurance) with no benefit limits, meaning this legislation would have negligible impact in those lines of business. In the individual market, all of our products provide coverage for prosthetics at regular plan levels with no benefit limits. Only one of these products provides coverage of orthotics, other than those devices associated with other state and federal mandates.

The reason for this exclusion is one of cost and choice. To mandate coverage as envisioned by HB 1612 on our individual products would increase plan cost by approximately .3%. We take our fiduciary responsibility to our members very seriously, and given the ever-increasing cost of coverage in the price-sensitive individual market insurers need the flexibility to make determinations on which benefits provide the best value for our members' dollars. Individuals have the option to purchase a Regence policy with coverage of orthotics if they so choose, but they should also have the option to choose a less expensive plan that fits their lifestyle but excludes such coverage.

Another factor the Department should strongly consider is the pending federal definition of "essential benefits" that beginning in 2014 will be required in nearly all health insurance policies with no benefit limits. If a benefit is not part of the essential benefits

package the state would be on the hook for the share of exchange subsidies attributed to those benefits, or else it would be faced with the difficult decision of taking away a mandated benefit.

Finally, we have serious concern with section 2 of the proposed legislation which states: “Coverage required under this section includes all services and supplies determined medically necessary by the treating physician to restore functionality to optimal levels.” To help control utilization cost for our customers, Regence employees a medical management policy for prosthetics and orthotics (as does Medicare). Removing our ability to do so would certainly increase cost. Therefore, we strongly recommend that the Department not endorse the approach envisioned by HB 1612.

Regence BlueShield again thanks you for the opportunity to submit comments to the Sunrise Review. We hope that this information is given careful consideration. Please don't hesitate to contact us with further questions.

Sincerely,



Chris Bandoli
Sr. Public Policy Administrator
Regence BlueShield

August 3, 2011

Mary Selecky, Secretary
Washington State Department of Health
PO BOX 47890
Olympia, WA 98504-7890

Dear Secretary Selecky,

Thank you for the opportunity to provide comment on the sunrise review regarding coverage for prosthetics and orthotics at a level at least equivalent to the coverage provided by Medicare. The desire by health care stakeholders to ensure that coverage for their specific niche in our health care community is well understood. However, we ask the Department to recommend to the Legislature that further action on this mandate be delayed until full implementation of the federal Patient Protection and Affordable Care Act (PPACA) has occurred.

The passage of the new federal law is changing the landscape for health care coverage and delivery of health care services throughout the country. This massive undertaking to revamp the health care system includes an appropriate timeline that not only provides states with time to implement the new requirements, but also provides consumers with time to adjust to the new costs these changes will bring. State actions that add additional costs to health coverage requirements are premature and should be more thoroughly evaluated once reform efforts have been fully implemented.

Federal reform efforts include new benefit mandates, some of which were implemented last year and drove premiums higher. Purchasers experienced premium rate increases of 15-39% last year, and 2-6% of those increased costs were attributed to the new PPACA coverage requirements. Unfortunately, the list of mandated benefits continues to grow and further compound costs. Just this last week an announcement was made that insurers must now include coverage for contraceptive services at no cost to individuals as part of the preventive services mandate that went into effect last year. Another mandate that will undeniably increase costs as someone is writing the prescription, someone is filling the prescription and some company is making the medication and these items are not free, these costs will be absorbed by the system and will ultimately be paid for by purchasers, forcing everyone's rates up.

Even more coverage changes are expected in just a few months. In addition to the mandates that have already gone into effect, the law requires the federal Department of Health and Human

Services (DHHS) to identify the “essential benefits” new health plans must include beginning in January 2014. PPACA already includes a requirement for coverage of “rehabilitative and habilitative services and devices” which will cover items related to prosthetics and orthotics, thus DHHS is already responsible for determining the extent to which prosthetics and orthotics will be covered in the new plans. DHHS will release the new requirements before the end of this year so action on a state-level mandate is clearly premature.

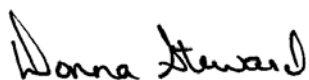
In addition to the cost increase to the consumer, also beginning in 2014, states will be required to pay state level subsidies for coverage that exceeds the federal requirements for all individuals eligible for the federal subsidies. The more mandates our state adds and retains that exceed the federal requirements, the more state general fund dollars must be used to support subsidies for those mandates. Given our current state budget situation, it does not seem fiscally prudent to potentially add new costs into the system without knowing whether the state will be obligated through general fund expenditures to pay for such costs. As it stands now, just adding this benefit to a primarily low number of state employees enrolled in managed care plans will increase costs to our already existing state employee benefit program by \$8 million the first year and those costs will nearly double by 2015.

Health care inflation, utilization, claims experience and access to new covered benefits each contribute to annual health care premium increases. Health care cost inflation has exceeded standard inflation by more than five points for at least the past six years, and there are no indications that this trend will slow any time soon. As these costs compound, employers struggle to maintain the coverage they currently have and any additional costs will force decisions that could ultimately leave them without coverage.

As you further consider your recommendation on this issue, I ask that you contemplate this mandate within the context of federal reform efforts as well as within the context of a struggling employer’s ability to provide coverage. Every dollar added is an additional per employee cost and the more these costs compound, the more employees who will lose access to coverage. The prudent response is to delay any further action on this and any other benefit mandate, until federal reforms are fully implemented and we are clearly aware of the federal requirements for coverage.

Thank you again for the opportunity to provide comment on this issue. Please feel to contact me at 360-943-1600 if you have any questions.

Sincerely,



Donna Steward
Association of WA Business
Government Affairs Director

August 4, 2011

Jack C. McRae
Senior Vice President

Secretary of Health Mary Selecky
Washington State Department of Health
P.O. Box 47850
Olympia, WA 98504-7850

RE: Prosthetics and Orthotics Sunrise Review

Dear Secretary Selecky:

On behalf of Premera Blue Cross, thank you for the opportunity to provide comments as part of the Department of Health (DOH) sunrise review process concerning a proposed prosthetic and custom orthotic parity bill.

I am writing to express our opposition to this mandate proposal. Our concerns relate to mandating benefits when options currently exist in the market for consumers and when these benefits will likely be addressed shortly due to federal healthcare reform. We are also concerned about the medical necessity language in the proposed legislation and the requirement for reimbursement to be equivalent to Medicare.

The majority of our plans already cover prosthetic and orthotic devices, including appropriate repairs and replacements. More specifically, none of our plans offered in the individual and small group markets have a lifetime maximum, dollar or number limit, specific to prosthetic coverage.

Most of our plans in the individual and small group markets also do not have an annual maximum for prosthetics, and instead, offer unlimited coverage. Almost all large employer plans cover prosthetics with no annual and lifetime maximums. Several of these changes were made to meet the federal healthcare reform requirements which were effective starting September 23, 2010. By October 2011, plans will have renewed with unlimited prosthetic benefits.

Similar to Medicare Part B cost sharing for devices, Premera members pay a deductible and 20% or 30% coinsurance for prosthetics, depending on plan design. This cost-sharing structure is similar to medical and surgical benefits.

We also have concerns with the timing of this benefit mandate proposal and question whether this issue should be addressed now, since the Department of Health and Human Services (HHS) is currently undergoing work to establish "essential health benefits" mandated by the Affordable Care Act. One of the ten categories plans must cover is "rehabilitative and habilitative services and devices," and we expect this category to address prosthetic coverage, at a minimum.

Section 1(2) of HB 1612 would further require carriers to cover “all services and supplies determined medically necessary by the treating physician to restore functionality to optimal levels.” Carriers typically perform medical management to review services and devices as medically necessary and appropriate for the member’s needs. Removing the ability of carriers to perform appropriate medical necessity review is certain to result in increased costs and impact patient safety and care.

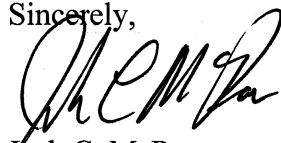
The Centers for Medicare and Medicaid Services (CMS) agrees with us in this regard. CMS has established a process to ensure the medical necessity of services being paid for by the Medicare program. CMS established the Medicare National Coverage Determination process in which Medicare coverage is specific to “whether an item or service is reasonable and necessary” as determined through the formal process, not by a treating physician. The proposed language is overly expansive and conflicts with both Medicare’s coverage determination process and medical management reviews that exist for all other service, devices, and conditions covered by carriers.

In addition, requiring the reimbursement rate for prosthetic and orthotic devices to be at least equivalent to the Medicare program will increase costs. Premera has negotiated rates with prosthetic and orthotic providers to the benefit of our members. Requiring carriers to pay the same rate as Medicare will only increase costs for consumers.

In conclusion, we do not support a mandate for prosthetic and orthotic coverage. We believe consumers should have access to coverage for prosthetics and orthotics, and to that end, Premera currently provides options for consumers. Plans that provide this coverage - most without any annual or lifetime limits for prosthetics and with cost sharing requirements similar to Medicare - already exist in the market for consumers. Since HHS will be issuing rules that are very likely to address prosthetic coverage, we urge the DOH to consider federal guidelines on this topic before taking action on another state specific mandate in the interim.

Thank you for the opportunity to offer our comments on this proposal.

Sincerely,



Jack C. McRae

JM/dgw



The Association of Washington Healthcare Plans

August 5, 2011

Sent via E-Mail & U.S. Postal Service

Mary Selecky, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504

Re: Prosthetics and Orthotics Benefit Sunrise Review

Dear Secretary Selecky,

On behalf of Association of Washington Healthcare Plan (AWHP) member healthcare plans, thank you for the opportunity to provide input as part of the Department of Health's (DOH) sunrise review process for prosthetics and orthotics. We hope the following comments will be of assistance to you.

AWHP is an alliance of our state's thirteen largest Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), and Disability insurers. Its diverse membership is comprised of local, regional, and national healthcare plans serving the needs of consumers, employers and public purchasers. Together, they provide health care coverage to over 4 million residents of Washington State.

Currently Available Coverage

All AWHP member healthcare plans offer products that provide some level of coverage for prosthetic devices --- ranging from unlimited coverage to a maximum annual limit for certain grandfathered health plans and coverage for orthotic devices

On page 2 of the applicant report is a "compilation of different types of restrictions that were found on prosthetic coverage in private insurance plans". The information provided in this matrix is out-of-date and no longer accurate. In example, healthcare plans have had to remove some limits per federal reform.

Medical Necessity Determination

HB 1612 legislation proposes that coverage be mandated for all services and supplies determined medically necessary by the treating physician. Medicare requires that they be ordered and prescribed by a licensed physician; however it is important to note that it leaves determination of medical necessity and medical management to the carrier.

HHS Essential Health Benefits

We believe the following questions should be strongly considered as part of the sunrise review process. How does the timing of the proposed coverage mandate relate to federal healthcare reform? How will it interface with the “essential health benefits” Health and Human Services (HHS) is expected to define by the end of 2011? (We understand coverage for prosthetics and orthotics is likely to be included in one of the categories specified as “rehabilitative and habilitative and devices”.)

Benefit Mandate Impacts

Washington State healthcare plans are under strong pressure to control coverage costs. The proposed HB 1612 mandate would take us in the opposite direction by requiring all plans offered to individuals and employers to cover prosthetic and orthotic coverage. As with many proposed mandates, it would likely provide some welcome financial relief for those faced with a particular condition or illness. We think it is only fair, however, to also consider the cost impact on other WA individuals, families and small businesses struggling to continue to afford healthcare coverage. Many of whom are facing the possibility of having no coverage at all, or, having to depend on our state’s safety net.

It should also be noted that Governor Gregoire, as part of her “Health Care Reform the WA Way” initiative, has set a goal of reducing the overall trend in health care spending in our state to no more than 4 percent annual growth.

Of additional concern with all such mandates is that they take away healthcare plan flexibility to design products reflecting purchaser needs, as well as effectively utilize quality and cost management tools.

Thank you again for the opportunity to provide these comments for your consideration. Please do not hesitate to contact me at 425-396-5375 if we can provide additional information or to discuss further.

Sincerely,



Sydney Smith Zvara
Executive Director

AWHP members include Aetna, CIGNA, Columbia United Providers, Community Health Plan of WA, Group Health, Kaiser Permanente, Molina, HealthNet, Sound Health Partners, Premera Blue Cross, Providence Health Plan, Regence BlueShield, & United Healthcare.

Written Testimony for the Prosthetics & Orthotics Mandated Benefit Sunrise Review

Submitted by Katherine B. Stewart, MS, OTR/L

On behalf of the Washington Occupational Therapy Association (WOTA)

August 5, 2011

The proposed bill HB 1612 (Washington Prosthetics & Orthotics Parity Bill) requires individual and group health plans to provide coverage for benefits for prosthetics and orthotics that are at least equivalent to the coverage provided by the federal Medicare program. Medicare law specifies that payment for custom-fabricated orthotics and prosthetics are furnished only by qualified providers including occupational therapists (42 U.S.C. 1395m(h)(1)(F)(iii)). Occupational therapists are licensed under the State of Washington law (RCW 18.59.020(2)) which specifically states that occupational therapy services include designing, fabricating or applying selected orthotic and prosthetic devices. Therefore, the Washington Occupational Therapy Association testified on February 14, 2011 in the House Health Care Committee to add an amendment to HB 1612 as stated below:

Sec.1(2) Coverage required under this section includes all services and supplies, **including orthotic and prosthetic devices and services provided by a licensed occupational therapist as defined by RCW 18.59.020(2)**, determined medically necessary by the treating physician to restore functionality to optimal levels.

WOTA's current position is the same as the testimony provided during the 2011 Legislative Session. As long as occupational therapists are included in the language of the Prosthetic & Orthotic Parity Bill, we plan to support this legislation.



GroupHealth

August 5, 2011

Ms. Sherry Thomas
P.O. Box 47850
Olympia, WA 98504-7850

Group Health Cooperative
Public Policy / Government Relations
GHQ-E4N

Group Health Headquarters
320 Westlake Avenue N, Suite 100
Seattle, WA 98109

www.ghc.org

RE: Mandated Benefit Sunrise Review – Coverage for Prosthetics and Orthotics

Dear Ms. Thomas:

Group Health appreciates the opportunity to provide comments on the proposal for coverage of prosthetics and orthotics as part of the Department of Health's (department) mandated benefit review process. We feel the "sunrise" review process is important as it allows for a thorough and thoughtful review of new or expanded health benefits that would not otherwise occur under the time compressed legislative session.

As you know, Group Health is an integrated care delivery system, serving 700,000 members in Washington State and northern Idaho. We are nationally recognized for innovative health care and strive for continuous improvement by focusing on better health outcomes and service excellence while reducing medical cost trends. In order to meet these goals, we care greatly about any new added costs to the health care system that may not provide substantial benefit to our patients.

Position on mandates

When considering the addition of any new covered benefit or service, Group Health carefully considers a variety of factors, including a careful review of evidence of clinical efficacy and care delivery options. Mandated benefits legislation or regulation can significantly interfere with or preclude evidence-based benefit design and innovation in care delivery. Mandates often come about by strong interest group lobbying; frequently they lack adequate demonstration of clinical efficacy or are poorly drafted. All too often, mandated benefits legislation or regulation rigidly define how, when, and by whom services must be delivered, thereby frustrating efforts to better and more effectively deliver care and services. Additionally, potential tradeoffs often are not considered or are minimized.

The cumulative effect of mandated benefits is higher health care costs for all. This, in turn, leads to a number of undesirable actions by employers seeking to control their health plan costs: dropping non-mandated benefits; increasing employee's share of health coverage costs; or even no longer offering employer-sponsored coverage. In addition, mandates encourage employers to self-fund, and therefore escape not only the imposition of mandates but also all state oversight of their health plans.

The cost of benefit mandates and the resulting impact on access to affordable coverage continues to be a concern both at the state and federal levels contributing to the financial strains on the health care system. The Affordable Care Act is intended to address many access and affordability issues and in fact, the federal government is directed to define the health care benefits for enrollees in state exchanges. The Department of Health and Human Services is expected to issue regulations on "essential health benefits" this fall. We believe any effort at the state level to prescribe benefits to be covered by health plans is premature.

Concerns with HB 1612

- The major impact of this proposal on Group Health would be financial - both for our delivery system and health plan operations. Currently we are able to contract at reimbursement terms lower than what Medicare pays. Several of our current suppliers offer us discounts below the Medicare fee schedule, and comment that they are able to still make their margins. The Medicare fee schedule ceiling seems unreasonable and unnecessary - it just raises costs.
- Requiring managed care plans to have at least two distinct prosthetics and orthotics providers in their network is burdensome. Group Health currently has a network in place that exceeds this requirement, though this language further restricts our ability to consolidate and focus our network should the opportunity be presented. There are national providers who would be willing to discount heavily in exchange for exclusivity.
- The proposal requires that prosthetic and orthotics coverage should be comparable to other medical services. We feel this is inappropriate and coverage should be comparable to other Durable Medical Equipment (DME) coverage. DME or Devices, Equipment, and Supplies are traditionally grouped together and are billed and or covered differently than a medical visit.
- Our plans currently cover medically necessary prosthetics, but only cover orthotics on a handful of plans as requested. The definition for "orthotic device" will likely be problematic, as it opens the door to providing a wide variety of OTS/OTC devices that many carriers currently deny as comfort or personal care items. We do not think the intent is to provide coverage for all sorts of shoe inserts, elastic back braces, etc.
- The proposal seems to negate application of medical necessity criteria by the health plan and leaves this determination to the treating physician. Although Medicare requires services and supplies to be ordered and prescribed by a licensed physician, it leaves the determination of medical necessity up to the carrier. This is important to note as it will drive up costs.
- The proposal creates an unlevel playing field as it only applies to commercial lines of business and not PEBB, BHP or Medicaid. This would mean coverage would be available for those in commercial lines of business, but not for those in public programs.
- Language should be clear that coverage for repair or replacement should not be due to loss, breakage from willful damage, neglect or wrongful use or due to personal preference.

Thank you again for the chance to offer our perspective on this proposal. We hope you find our comments helpful in your evaluation and recommendations for coverage of prosthetics and orthotics for Washington citizens.

Sincerely,



Scott Plack

Director, State Government Relations

To: Richard Onizuka, Dennis Martin

From: Pam Martin

July 26, 2011

Re: Sunrise review – Prosthetics and Orthotics Insurance Coverage

Thank you for the opportunity to provide comments on the Sunrise Review of House Bill 1612 regarding an insurance mandate for coverage of prosthetics and orthotics.

The Health Care Authority reviewed this bill during the most recent legislative session. We also met informally with the proponents to discuss concerns with the language of the bill. We offered suggestions to clarify the implied scope of the bill that influenced our analysis of the fiscal and operational impacts to the PEB health plans. We would like to take this opportunity to restate our concerns.

Comments on the Applicant Report

Section (a)(ii) *To what extent is the benefit already generally available* – The PEB health plans do cover prosthetics. They do not provide coverage for all of the types of orthotic devices that may be required if this bill is enacted. We will discuss this matter in greater detail in our remarks related to the language of the bill. The PEB plans do perform reviews of some durable medical equipment and prosthetics or may require preauthorization with a statement of medical necessity from the prescribing physician.

Section (b)(ii) *To what extent will the coverage increase the appropriate use of the benefit?* – The Applicant indicates that this mandate will not increase utilization. The issue is not limited to new users. The application does not address the matter of replacements. There will likely be an increase in utilization if the PEB plans are not allowed to review claims for medical necessity in terms of replacement prosthetics. PEB plans do allow for replacements necessary due to patient growth, stump changes, etc. Also, this bill does not allow any limitation on high end technological prosthetics that exceed basic needs such as C-legs and specialized orthotics that may be of benefit to athletes or other active (e.g. Level 4) amputees. The bill mandates that if the patient's physician orders a prosthetic or orthotic, it is deemed to be medically necessary and appropriate.

Section (b)(iv) *To what extent will the benefit increase or decrease the administrative expense of health carriers and the premium and administrative expense of policyholders?*

The Application states “By putting prostheses on par with other basic, medical services the number of appeals the company must process and therefore expend money on would be decreased.” This proposal goes beyond putting prosthetics and orthotics “on par” with other basic medical services. The PEB plans apply standards of medical necessity to all covered services. PEB plans are required by law to apply the findings of the Washington State Health Technology Assessment Program to PEB benefits. This proposal may create conflicts with that

law and does not allow for any critical review of prosthetics and orthotics. They must be covered as ordered by the patient's prescribing physician.

Section (b)(v) *What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage?*

PEB received information from one of its insured plans, Group Health of Washington, that with the broad scope of the bill, they estimated this mandate could increase premiums by one percent. The Application includes cost estimates provided by other states where this mandate was introduced. Most estimates are lower than one percent. It should be noted that bills introduced or passed in these other states may not have been identical to the wording in the HB 1612.

For example, the mandate passed in the Commonwealth of Virginia is not a prosthetics benefit mandate. Virginia considered that, but passed only a mandated offering of coverage for prosthetics. That bill also limited the frequency of replacements to once in a 12-month period. The definition of prosthetics and orthotics in the New Jersey mandate bill were not the same as the definitions in HB 1612.

Comments on HB 1612

The language in this bill has been discussed with the proponents, as stated earlier. HCA recommended a clearer definition of orthotics that would be related specifically to those used in conjunction with prosthetics. PEB plans exclude coverage of shoe inserts used by a significant number of members for various reasons unrelated to medical needs of amputees. The Applicant stated in a discussion with HCA staff that orthotics referenced in the bill are specifically used with prosthetics. That is not apparent in the language of the bill. Without a clearer orthotics definition in the bill, this could require coverage of thousands of basic and custom shoe inserts not currently covered by PEB plans.

The cost for these devices can be hundreds of dollars per unit. The bill does not allow plans to limit coverage based on a review of medical necessity. This is the major reason for a cost impact estimate of at least one percent.

We have concerns about the inability of plans to apply any standards for medical necessity to these devices. As stated earlier, utilization and health care costs will be impacted if the sole arbiter of the necessity for frequency of purchase or the technological level of orthotics or prosthetic devices needed is the patient's own physician. No other benefits mandated prohibit a PEB health plan from performing a medical necessity review, and deny coverage in the event the service does not meet the definition of medical necessity or is determined to be experimental or investigational.

HCA also has concerns about the provider access and reimbursement requirements of this bill. PEB plans include HMO plans that may or may not have reimbursement levels equal to Medicare payment levels. They may also provide limited but adequate member access to a orthotist or prosthetist. PEB benefits for prosthetics already limit member out of pocket costs

and the provision in this bill to mandate a specific level of reimbursement does not allow for the plans to negotiate with providers for the best price for our members.

Fiscal Impact to PEB Budget

The following chart shows the measurement used to calculate a 1%percent increase in cost for the PEB insured plan health costs.

Assume 1% increased Premium Cost in Non-Medicare Insured Risk Pool					
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Subscribers	55,497	55,497	55,497	55,497	55,497
Insured Avg Premium	\$ 865.69	\$ 930.65	\$ 1,000.45	\$ 1,075.48	\$ 1,156.14
Monthly Cost	\$48,043,198	\$51,648,283	\$55,521,904	\$59,686,047	\$64,162,501
Annualize Cost	\$576,518,375	\$619,779,397	\$666,262,851	\$716,232,565	\$769,950,008
1% Increased Cost due to Mandated Benefit	\$5,765,184	\$6,197,794	\$6,662,629	\$7,162,326	\$7,699,500
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Convert to Fiscal Years	\$2,882,592	\$5,981,489	\$6,430,211	\$6,912,477	\$7,430,913

Fiscal Assumptions:

- This bill will not impact the Basic Health Plan and is not required in the PEBB self-insured plans. Specifically, UMP will not offer expanded benefits for prosthetics and orthotics. However, the PEBB insured plans such as Group Health and Kaiser are directed to provide the expanded benefits in this bill.
- The premium increase will impact the PEBB Non-Medicare risk pool only.
- HCA assumes subscriber enrollment of 55,497 in the Non-Medicare Insured Plan for Calendar Year 2012 and each year thereafter.
- The benefits must be at least equivalent to Medicare benefits.
- “Prosthetic device” has a limited definition:” an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.”
- The mandate requires health plans coverage at least equal to what Medicare pays, with coverage comparable to other benefits, without arbitrary caps or annual or lifetime restrictions.
- Coverage must include any repair or replacement of a device that is determined to be medically necessary by the treating physician to restore or maintain the ability to complete activities of daily living or essential job-related activities that are not solely for comfort or convenience.
- Managed care plans must provide access to related clinical care and prosthetic and orthotic devices and technology from not less than two providers in the plan’s network.

Conclusion

The HCA currently provides comprehensive coverage of prosthetics to PEBB members without this broad mandate. We are available to work with the Applicant to address the areas of concern discussed here.

The following comments are submitted on behalf of the Washington State Podiatric Medical Association (WSPMA). WSPMA supports HB 1612, and we apologize for not registering this support earlier. We are very grateful to the Department of Health (DOH) for the extended comment period.

As drafted, HB 1612 is very broad, and we thought inclusive of all types of orthotics, as well as care provided by all physicians. Since our members are podiatric physicians, we simply assumed that they would be included as providers.

However, we understand that comments and questions arose during the sunrise hearing, whereby there was concern about including traditional foot orthotics, unrelated to a prosthetic. If foot orthotics were excluded, then the question was raised as to whether podiatric physicians should be included as providers.

We believe podiatric physicians should continue to be included as providers under any revisions to HB 1612. In addition to foot orthotics, podiatric physicians also may provide at times orthotic devices and prosthetic devices such as an ankle/foot orthotic which would be more of a brace. This would clearly seem to fall within the legislative intent of the bill.

Finally, our thanks again to DOH for allowing an extended comment period. If there are any other questions about the care provided by podiatric physicians, please contact me.

Susan Scanlan, D.P.M., Executive Director, Washington State Podiatric Medical Association

As per our previous submission and testimony, the Washington Occupational Therapy Association is in support of HB 1612 as long as the language of the bill states the following:

Sec 1 (2) Coverage required under this section includes all services and supplies, including orthotic and prosthetic devices and services provided by a licensed Occupational Therapist as defined by RCW 18.59.020(2), determined medically necessary by the treating physician to restore functionality to optimal levels.

Our rationale for this request includes:

- 1) Medicare rules and regulation specifies that payment for custom-fabricated orthotics and prosthetics are furnished only by qualified providers, including Occupational Therapists (42 U.S.C. 1395m(h)(1)(F)(iii).
- 2) Occupational Therapists are licensed under the laws of the State of Washington (RCW18.59); this law specifically states that Occupational Therapy services “include designing, fabricating or applying selected orthotic and prosthetic devices.” (RCW18.59.020(2))

As part of the Sunrise Review process, the Washington Occupational Therapy Association appreciates the opportunity to clarify the role of occupational therapy in orthotics and prosthetics.

Occupational therapy services in Washington State are provided under the referral and direction of a physician or other approved medical provider in all medical cases (RCW 18.59.110). As part of the documented occupational therapy treatment plan, the occupational therapist selects the orthotic and prosthetic devices that are needed to restore, enhance, and/or improve occupational performance (e.g., work, self-care, leisure or other areas of function) based on the medical need and goals of the patient. If the medical status of the patient changes (e.g., changes in wound healing, range of motion, strength, and muscle tone), the orthotic or prosthetic device may require adaptation, modification, adjustment, or revision. The occupational therapist also provides the patient with the necessary instructions in the use and care of an orthotic or prosthetic device.

Occupational therapists select, design, fabricate, and adjust orthotic and prosthetic devices to meet the medical needs and functional goals of the patient. Regarding orthotic devices, the goal may be to position a limb to reduce hypertonicity, reduce a contracture following a neurological incident, provide positioning during wound care or burn healing, facilitate functional movement or protect movement, protect an extremity during healing or from further injury, etc. In medical cases, these devices are provided under the order of a physician or other authorized medical provider and are intended for a specific treatment goal. The occupational therapist, in collaboration with the treatment team, often provides direct input about a specific orthotic or prosthetic device. In many instances, the occupational therapist will design and fabricate the appropriate device based upon the referring physician's order, evaluation of the patient, establishment of appropriate treatment goals, patient's medical needs, and available resources. During the course of treatment the orthotic or prosthetic device may be replaced, modified, or adjusted, depending on the needs of the patient. These devices are patient-specific and are not intended for use by other than the patient to whom it is provided. Occupational therapists are not limited in the type or function of the orthotic or prosthetic devices that they may provide.

The frequency with which an occupational therapist provides orthotic or prosthetic devices depends upon the practice setting and population being served. Occupational therapists who work in Hand Therapy or Physical Medicine & Rehabilitation settings provide these devices on a more frequent basis than occupational therapists who work in other settings, such as a school-based or mental health practice. As an example, one occupational therapy clinic in the State of Washington that treats patients with specific hand and upper extremity injury and disease has three locations and has provided over 2,200 splints and orthotic devices over the past year. In this clinic, the occupational therapists may treat up to 10 patients a day who require this service. This service equates to approximately 15-20% of the income for this clinic setting. Other practice settings will vary according to their own unique situation.

We hope the information above clarifies the role of occupational therapy in orthotics and prosthetics.

For a more detailed description of the role of occupational therapy in orthotics and prosthetics, please refer to the American Occupational Therapy Association web page links:

The Occupational Therapy Role in Rehabilitation for the Person with an Upper Limb Amputation
<http://www.aota.org/Practitioners/Resources/Docs/FactSheets/Conditions/39922.aspx>

The Role of Occupational Therapy for Rehabilitation of the Upper Extremity
<http://www.aota.org/Practitioners/Resources/Docs/FactSheets/Conditions/UE.aspx>

Katherine B. Stewart, MS, OTR/L and John Hatcher, OTR/L, Washington Occupational Therapy Association (WOTA)

I am writing in support of HB 1612. My name is Kirk Douglass, I am a Licensed Orthotist /Prosthetist in Washington State and own my own Practice in North Seattle. I support this Bill as I found such wide spread differences in Orthotic and Prosthetic coverage from Carrier to Carrier, and even from policy to policy within the same Carrier. Clearly Medicare guidelines are not covered within Private Insurances, some exclude Prosthetics entirely, some exclude select components as "experimental" even though Medicare has determined they are not, some cover Orthotics but no shoes for diabetics (Medicare does cover this) while other cover diabetic shoes while they have no other Orthotic coverage. Even if there is Prosthetic or Orthotic coverage, there is no consistency as to what they cover. I have personally experienced limits to one prosthesis a lifetime (impractical to say the least), Prosthetic coverage only if you are under 18 years of age, I have even received prior authorization only to find out that what they authorized was not a covered benefit under the subscribers plan (try to figure this out, I couldn't).

Orthotic and Prosthetic coverage can be spotty and chaotic to say the least, and if our office finds it to be this way, imagine how difficult it is for the patients to weed through their own policy. Orthotics and Prosthetics is not something we all necessarily anticipate a need for, but when needed is critical to one's recovery and/or mobility. Working in the field I see how both having and not having coverage effects people; those who have it progress with their recovery/life, while those who don't have coverage can become depended on family or state assistance. It is because of this imbalance I've witnessed that I support HB 1612; Orthotics and Prosthetics are a necessary service that should be available when one finds they need them.

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