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Testimony from Dan Ignaszewski on SB 17

FTR

Good afternoon, Chairman Crisco, and members of the Joint Committee on Insurance and Real Estate. My name is Dan Ignaszewski. I am the Government Relations Coordinator for the Amputee Coalition. The Amputee Coalition is the only national non-profit organization serving more than two million people with limb loss and more than twenty eight million people at risk for amputation. We are proudly celebrating our 25th anniversary this year and continue to represent the needs of people of all ages living with the loss or absence of limbs. We have constituents, industry partners, peer visitors and support group leaders throughout the state of Connecticut and around the country, and as such would like to submit testimony in support of SB 17.

SB 17 is an important bill for the limb loss community. There are nearly two million Americans living with limb loss or limb deficiency as a result of disease, trauma or birth defect, including nearly 20,000 here in Connecticut. When looking at SB 17, and specifically section 3 of the bill relating to prosthetic coverage, it's important to take into account that this is an issue about access to restorative care and it is a decision made between a doctor and a patient. Without this limb restoration, life cannot be resumed in a normal way. Restorative prosthetics are the difference between being able to walk or being wheel chair bound, being able to work or not, and being able to conduct activities of daily living or not. Prosthetics are prescribed by physicians and prescriptions for these devices are based on clear guidelines for medical necessity. These guidelines require doctors to take into account an individual's functional abilities, the rehabilitative expectations of the patient, the physical condition of the residual limb, other health issues such as vascular or arthritic problems, lifestyle factors including employment and activity levels, independent living status, timeframe for recovery and access to care. These devices are restorative, because unlike other devices lumped into the "Durable Medical Equipment" category like crutches, wheel chairs, and walkers, prosthetic devices provide an unmatched level of independence and restorative mobility.

It's also important to realize that prosthetic devices are **the only** tool which comes close to restoring functionality for individuals with limb loss. The Veterans Administration, Medicare, Medicaid, and other state rehabilitation programs have been covering prosthetics for years at appropriate levels. Unfortunately, insurance companies have been imposing caps and restrictions on this important care. The most common cap we find is one of \$2,500 per year, but even more egregiously is the practice of providing only one limb per lifetime. Obviously this is unimaginable for an amputee that has lost two limbs in a car accident, or for the child who was born with a limb difference who will need to get new prosthetics fitted as they grow. We have even heard stories of individuals being forced to stop working in order to become eligible for state and federal programs that allow them to get the prosthetic care they need so they can get back to being active and contributing members of society. These caps and restrictions create a climate where individuals may be shifted from their private insurance to publicly funded insurance in order to receive the prosthetic devices they need. All of this occurs after the individual has been paying premiums to the private insurer for the purpose of providing necessary health care in case of a catastrophic health need.

Often times we hear from the insurance industry about vast increases in costs that would occur if they were required to provide coverage for prosthetic devices. However these assessments have not been proven to be true and never take into account the reduced costs of covering secondary complications which occur when the primary needs are not appropriately met SB 17 very simply allows physicians and prosthetists to do their jobs and prescribe the most appropriate device for an individual's needs based on their medical necessity, and restore amputees functionality allowing them to reach their full potential.

There are currently 19 states that have passed laws similar to SB 17, and several states have already introduced or are awaiting introduction of bills in their respective legislatures in 2011. Several of the 19 states that have passed prosthetic parity laws have also conducted state sponsored independent cost studies to review and document the affect of covering prosthetics on individuals, the insurance companies, and businesses. In every single one of the studies that have been conducted, the states have consistently found that cost of coverage would be low, finding that on average, insurance premiums would rise only about twelve cents per member per month.

Some of these same state studies have found that by curtailing or eliminating coverage of these vital services it can actually cost more money in the long run due to costly secondary complications associated with a forced sedentary lifestyle. I have attached with my testimony the key findings detailing this information from the independent studies that have been commissioned regarding legislation for fair insurance access to prosthetic devices. It is clear that by providing access to appropriate care when a prosthetic device is determined to be the most appropriate prescription, amputees are able to remain active, employed members of the community and not be subject to the complications that can result from a sedentary lifestyle.

We've also heard health insurers say that if this bill passes, "everyone will get the most expensive, computerized prosthetic device." This is simply not true. It certainly has not been true in any of the other nineteen states that have passed these bills. By passing this bill you would be reaffirming the fact that this is a medical decision between a doctor and a patient, and you would be allowing doctors to prescribe the most appropriate device for their patients' needs. You would not tell someone they could only have \$2,500 toward a hip replacement, or that they're allowed one knee replacement per lifetime. There's a reason there are no caps and restrictions on internal prosthetic devices like these; because they are essential to restore function to an individual. External prosthetic devices are just as essential to an amputee as a hip joint is to someone with debilitating arthritis and it should be treated the same way. This bill would simply allow doctors to treat prosthetic devices like these and other restorative benefits within an insurance policy.

Finally, people expect to be covered by their insurance in the event of a catastrophic illness or injury. Certainly 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 covering prosthetic devices for individuals who need them, individuals are not being given the chance to reach their full potential.

We ask you to take this opportunity today to ensure that people with limb loss in Connecticut are given access to the care they need to remain contributing members of society instead of dependent upon it. **Arms and legs are not luxury items, and they shouldn't be treated as such.** I hope you will recommend moving this bill forward for the good health and well being of the 20,000 amputees in Connecticut. Thank you for your time and consideration.

Submitted by:

Dan Ignaszewski
Government Relations Coordinator
The Amputee Coalition
Phone: 202-742-1885
Email: Dan@amputee-coalition.org

Amputee Coalition
900 East Hill Avenue, Suite 205
Knoxville, TN 37915
888 267-5669 Telephone
865 524-8772 Telephone
865 525-7917 Fax
amputee-coalition.org

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.