# REPORT OF THE
# SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

## House Bill 383
## Mandated Coverage of Lymphedema

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2003

January 10, 2003

To: The Honorable Mark Warner
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 383 regarding a proposed mandate of coverage for lymphedema.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

# SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

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## INTRODUCTION

The House Committee on Commerce and Labor referred House Bill 383 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) during the 2002 Session of the General Assembly. House Bill 383 was introduced by Delegate Leo C. Wardrup, Jr.

The Advisory Commission held a public hearing on October 10, 2002, in Richmond to receive public comments on House Bill 383. In addition to the patron, Delegate Wardrup, six speakers addressed the proposal. The chairman from Virginia Commonwealth University (VCU) Medical College of Virginia (MCV) Health System Division of Surgical Oncology, a medical oncologist, a physical therapist, a registered nurse, and a patient spoke in favor of House Bill 383. A representative from the Virginia Association of Health Plans (VAHP) spoke in opposition to the bill.

In addition, written comments in support of the bill were provided by the American Cancer Society (ACS), American Physical Therapy Association, Roanoke Chapter of the Oncology Nursing Society, Blue Ridge of Virginia Chapter of the Oncology Nursing Society, Hill City of Virginia Chapter of the Oncology Nursing Society, Northern Virginia Chapter of the Oncology Nursing Society, Virginia Breast Cancer Foundation, VCU MCV Health System Division of Surgical Oncology, Virginia Occupational Therapy Association, two physical therapists, an occupational therapist, and a patient. Written comments in opposition to House Bill 383 were provided by Trigon Blue Cross Blue Shield, the Virginia Chamber of Commerce, the Health Insurance Association of America, and the VAHP.

## SUMMARY OF PROPOSED LEGISLATION

The bill adds § 38.2-3418.14 to the Code of Virginia to require insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and HMOs providing health care plans to provide coverage for lymphedema.

Subsection B of the original bill requires coverage for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law. The terms “equipment” and “supplies” shall not be considered durable medical equipment.

Subsection C of the original bill requires that to qualify for coverage, lymphedema outpatient self-management training, education, and therapy should be provided by a certified, registered or licensed health care professional with a minimum of

120 hours of lymphedema therapy training. A managed care health insurance plan (MCHIP), as defined in Chapter 58 (§ 38.2-5800 et seq.) of the Code of Virginia, may require such health care professional to be a member of the plan's provider network. The network should include sufficient health care professionals that are qualified by specific education, experience, and credentials to provide the covered benefits.

Subsection D of the original bill prohibits insurers, corporations, or HMOs from imposing copayments, fees, or conditions on persons for these benefits that are not equally imposed on all individuals in the same benefit category. The bill also prohibits insurers, corporations, or HMOs from imposing any policy-year or calendar-year dollar or durational benefit limitations or maximums for benefits provided under this section.

The original bill applies to insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed or extended in the Commonwealth on or after July 1, 2002, or at any time thereafter when the term is changed or the premium adjustment is made.

The bill does not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act (Medicare), or any other similar coverage under state or federal governmental plans.

At the November 12, 2002 and the December 11, 2002 meetings of Advisory Commission, amended language was submitted on behalf of the patron for consideration by the Advisory Commission. The amended bill deletes the terms "equipment" and "supplies" and removes the provision prohibiting their being considered durable medical equipment from subsection B. The amended bill also removes the requirements that lymphedema outpatient self-management training, education, and therapy be provided by a certified, registered or licensed health care professional that has a minimum 120 hours of lymphedema therapy training in subsection C. Subsection D of the amended bill prohibits insurers, corporations, or HMOs from imposing copayments and fees on persons for these benefits that are not equally imposed on all individuals in the same benefit category. The amended bill also prohibits insurers, corporations, or HMOs from imposing any policy-year or calendar-year or durational benefit limitations or maximums for benefits or services provided under subsection D. In subsection E, the amended bill extends all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on or after to January 1, 2004.

According to the National Lymphedema Network (NLN), lymphedema is an accumulation of lymphatic fluid in the interstitial tissue that causes swelling in the arms, legs, or other parts of the body and affects both men and women. Lymphedema normally develops when lymphatic vessels are missing or impaired (primary lymphedema) or when the lymph vessels are damaged or nodes are removed (secondary lymphedema). When the impairment becomes so immense that the lymphatic fluid exceeds the lymphatic transport capacity, an abnormal amount of protein-rich fluid collects in the tissues of the affected area.

The NLN stated that primary lymphedema can affect from one to as many as four limbs or any areas of the body. It can be present at birth, develop at the onset of puberty, or in adulthood. Some causes of primary lymphedema are unknown or could be associated with arterialvenous abnormalities (AV malformations) such as hemangioma, lymphangioma, Port Wine Strain, and Klippel Trenaury. Secondary lymphedema, an acquired lymphedema, can occur immediately postoperatively, within a few months, a couple of years, or 20 years or more after cancer therapy. It can develop from the result of radiation, infection, or trauma. Also, patients are normally put at risk of developing secondary lymphedema as a result of specific surgeries, such as surgery for melanoma or breast, gynecological, head and neck, prostate or testicular, bladder or colon cancer that require removal of lymph nodes. Patients that use radiation therapy for treatment of various cancers and some acquired immunodeficiency syndrome (AIDS)-related diseases, such as Kaposi-Sarcoma, can damage healthy lymph nodes and vessels that eventually could cause scar tissue to form that interrupts the normal flow of the lymphatic fluid. The NLN notes that it is very important to carefully monitor the radiated area for any skin changes that consist of increased temperature, discoloration, or blistering that can lead to the development of lymphedema.

## SYMPTOMS

According to the NLN, the symptoms of lymphedema to be concerned with include a full sensation in the limbs, skin feeling tight, decreased flexibility in the hand, wrist or ankle, difficulty fitting into clothing in one specific area, or a tightness of the ring, wristband, and bracelet. The stages of lymphedema ranged from mild, stage 1 to severe, stage 3. Stage 1 is characterized by tissue that is still at the pitting stage. When the skin is pressed by fingertips, the area holds the indentation. During the moderate stage 2, lymphedema is characterized by tissue of a spongy consistency that is non-pitting, the skin bounces back without the formation of indentation. At stage 3, the swelling is irreversible and usually the limbs are very large. The tissue is hard and unresponsive. During this stage, some patients may consider undergoing reconstructive surgery called debulking.

## SOCIAL IMPACT

According to the information provided by the ACS, lymphedema is a seriously undiagnosed and underdiagnosed condition that is sometimes called the “hidden epidemic.” The ACS reported that unfortunately, complete and accurate data on the number of incidences of lymphedema is not available at this time. It has been estimated that there are approximately between 2 and 8 million patients living with lymphedema in the United States. The single largest group of patients diagnosed with lymphedema is found among the breast cancer population in the United States.

The ACS reported that in the Commonwealth of Virginia, approximately 5,000 people will be diagnosed with breast cancer during the year 2002. Of the 5,000 patients, 30% will develop upper extremity lymphedema as a result of cancer treatments. According to the publication, entitled “Mid-Atlantic Division Cancer Facts and Figures 2002,” the ACS reported a total of 21,198 cases of patients diagnosed with breast cancer in Virginia between 1995 and 1999. Those cases could potentially result in 6,350 cases of arm lymphedema.

## FINANCIAL IMPACT

Information was provided by the ACS based on a survey of five treatment centers in Virginia providing specialized lymphedema treatment including complex decongestive therapy (CDT), a multi-modal treatment. The centers reported an average cost of $250 per visit for up to 1.50 hours of treatment. The average length of treatment ranged from 2 to 4 weeks or up to 20 visits depending on the severity of the lymphedema and the areas involved such as the unilateral arm or the bilateral legs.

The ACS stated that some complications of untreated lymphedema can be the development of open draining wounds that require costly medical management to heal and that frequent occurrence could result in recurrent infections, loss of work time, or progressive swelling necessitating disability.

## MEDICAL EFFICACY

According to the NLN, preparing the treatment program for patients depends on the severity of lymphedema. The recommended treatment plan should be determined using an approach that is based on the CDT. The CDT method includes the following: manual lymphatic drainage; bandaging; proper skin care and diet; compression garments, sleeves and stockings; remedial exercises; self-manual lymphatic drainage and bandaging; and continuing to follow prophylactic methods. When lymphedema is left untreated, the protein-rich fluid not only causes tissue channels to increase in size and number, but it also reduces oxygen availability in the transport system that interferes with wound healing. At this state, the swollen limbs become a culture medium for bacteria and subsequent recurrent infections known as lymphangitis. Also, untreated lymphedema can lead to a loss or decrease of functioning of the limbs, skin breakdown, chronic infections, and occasionally irreversible complications.

## PRIOR RECOGNITION

In 2001, House Joint Resolution No. 524 designated March 6 and each succeeding year as Lymphedema D-Day in Virginia. The resolution stated that swelling caused by the accumulation of lymphatic fluid can lead to severe infection or loss of the use of limbs. Patients that are suffering from lymphedema must tolerate physical discomfort and disfigurement and endure the suffering caused by these symptoms. The resolution noted that lymphedema has no cure, and it can occur at any time. Patients diagnosed with lymphedema may experience physical, psychological, and financial hardship. The NLN sponsored Lymphedema D-Day to honor patients and to increase the awareness of the treatment and severity of this condition. The General Assembly encouraged the citizens of the Commonwealth to respect and support patients that are living and coping with this devastating condition.

## CURRENT INDUSTRY PRACTICES

The State Corporation Commission Bureau of Insurance recently surveyed 60 of the top writers of accident and sickness insurance in Virginia regarding each of the bills to be reviewed by the Advisory Commission in 2002. Fifty companies responded by May 28, 2002. Fourteen indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the 36 respondents that completed the survey, 26 reported that they currently provide the coverage required by House Bill 383.

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.15 to $2.00 per month per standard individual policyholder and from $.02 to $5.53 per month per standard group certificate to provide the coverage required by House Bill 383. Insurers providing coverage on an optional basis provided cost figures of $.25 to $5.58 per month per individual policyholder and from $.25 to $3.98 per month per group certificate holder for the coverage required by House Bill 383.

## SIMILAR LEGISLATION IN OTHER STATES

According to information from the National Insurance Law Service, ten states have passed some type of legislation requiring coverage for lymphedema in connection with receiving medical and surgical benefits for a mastectomy.

Arizona requires that all policies provide coverage for surgical services for a mastectomy and cover mastectomy for surgical services for reconstruction of the breast on which the mastectomy was performed. Coverage must also include surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedema, and at least two external postoperative prostheses.

California requires all health service plans to provide coverage for surgical procedures known as mastectomies and lymph node dissections and all complications from a mastectomy, including lymphedema.

Kansas requires all insurers issuing individual or group health insurance policies, medical service plans, corporations providing contracts, fraternal benefit societies or HMOs providing coverage for accident and health services to provide medical and surgical benefits with respect to a mastectomy. Policies must provide coverage for any participant or beneficiary that is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, and coverage must be included for prostheses and physical complications in all stages of mastectomy, including lymphedema.

Louisiana requires all insurers issuing individual or group health insurance policies to provide coverage for medical and surgical benefits with respect to a mastectomy. Policies must provide coverage for a participant or beneficiary that is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy. Coverage must include reconstruction of the breast on which the mastectomy has been performed. Coverage must also include surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedema, and in a manner determined in consultation with the attending physician and the patient.

Mississippi requires all insurers issuing individual or group health insurance policies to provide coverage for medical and surgical benefits with respect to a mastectomy. Policies must provide coverage for an insured or enrollee that is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy. Coverage must include all stages of reconstruction of the breast on which the mastectomy has been performed. Coverage must include surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedema, and in a manner determined in consultation with the attending physician and the patient.

Nebraska requires all group sickness and accident insurance policies, subscriber contracts, or HMOs to provide medical and surgical benefits with respect to a mastectomy. Policies must provide coverage for a participant or beneficiary that is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy. Coverage must include all stages of reconstruction of the breast on which the mastectomy has been performed. Coverage must also include surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedema, and in a manner determined in consultation with the attending physician and the patient.

North Carolina requires all health care plans that provide coverage for mastectomy to provide coverage for reconstructive breast surgery following a mastectomy. Coverage must include all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to established symmetry if reconstructive surgery on a diseased breast is performed. Coverage must also include prostheses and physical complications in all stages of mastectomy, including lymphedemas.

North Dakota requires all health insurers in the group or individual markets and HMOs that provide a mastectomy benefit to provide coverage for prostheses and physical complications for all stages of mastectomy, including lymphedema.

Texas requires health benefit plans to provide coverage for reconstructive surgery after mastectomy, surgery and reconstruction of the other breast for symmetry, and prostheses and treatment of complications resulting from a mastectomy, including lymphedema.

Utah requires that if an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, coverage must be provided in consultation of the attending physician and the patients for prostheses and physical complications with regards to all stages of mastectomy, including lymphedema.

In New York, Assembly Bill 7607, a carryover bill from the 2001 Session, is still pending in the Insurance Committee. If enacted, the bill would require insurers to provide coverage for the diagnosis and treatment of lymphedema.

## REVIEW CRITERIA

### SOCIAL IMPACT

*a. The extent to which the treatment or service is generally utilized by a significant portion of the population.*

According to the information provided by the ACS, lymphedema is a seriously undiagnosed and underdiagnosed condition that is sometimes called the "hidden epidemic." The ACS reported that unfortunately, complete and accurate data on the number of incidences of lymphedema is not available at this time. It has been estimated that there are approximately between 2 and 8 million patients living with lymphedema in the United States. The single largest group of patients diagnosed with lymphedema is found among the breast cancer population in the United States.

According to the publication, entitled "Mid-Atlantic Division Cancer Facts and Figures 2002," the ACS reported a total of 21,198 cases of patients diagnosed with breast cancer in Virginia between 1995 and 1999. Those cases could potentially result in 6,350 cases of arm lymphedema.

*b. The extent to which insurance coverage for the treatment or service is already available.*

In a 2002 State Corporation Commission's Bureau of Insurance survey of the top sixty writers of accident and sickness insurance in Virginia, thirty-six companies currently writing applicable business in Virginia responded. Of the 36, twenty-six companies (72%) already provide the coverage required by House Bill 383.

*c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.*

Information was not presented on the number of people that have not been treated because of a lack of coverage. However, according to the ACS, some complications of untreated lymphedema can be the development of open draining wounds that require costly medical management to heal and that frequent occurrences could result in recurrent infections, loss of work time, or progressive swelling necessitating disability.

*d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.*

Information was provided by the ACS based on a survey of five treatment centers in Virginia providing specialized lymphedema treatment including complex decongestive therapy, a multi-modal treatment. The centers reported an average cost of $250 per visit for up to 1.50 hours of treatment. The average length of treatment ranged from 2 to 4 weeks or up to 20 visits depending on the severity of the lymphedema and the areas involved such as the unilateral arm or the bilateral legs.

In written comments, a physical therapist stated that even though some insurance companies cover some aspects of lymphedema treatment, many insurance companies do not cover equipment costs, such as compression garments, bandages, and compression units. Many patients cannot afford these out-of-pocket expenses, consequently causing their chronic and progressive condition to go untreated and to degenerate over time. The physical therapist reported that compression garments that are worn daily cost from $450 to more than $1,500 per year.

According to an article, entitled “Lymphedema Changes Patients Life,” dated February 24, 2000, reported that the average price of a compression sleeve is $55, a glove is $45, a custom sleeve can cost about $260, and a custom glove is about $245.

*e. The level of public demand for the treatment or service.*

The ACS reported that in the Commonwealth of Virginia, approximately 5,000 people will be diagnosed with breast cancer during the year 2002. Of the 5,000 patients, 30% will develop upper extremity lymphedema as a result of cancer treatments. According to the publication, entitled “Mid-Atlantic Division Cancer Facts and Figures 2002,” the ACS reported a total of 21,198 cases of patients diagnosed with breast cancer in Virginia between 1995 and 1999. Those cases could potentially result in 6,350 cases of arm lymphedema.

*f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

Five concerned citizens testified in favor of House Bill 383 at the public hearing. They stated that requiring insurance companies to provide coverage for the treatment of lymphedema will provide patients access to a protocol that has proven to be effective and will also provide them with the knowledge and skills needed to manage their condition. They believe that early treatment and self-management will curtail future complications and costs.

Written comments supporting House Bill 383 were received from the Oncology Nursing Society Roanoke Chapter and the Virginia Breast Cancer Foundation. They reported that approximately 30% of breast cancer survivors that had lymph node dissection and radiation will suffer from lymphedema. The Oncology Nursing Society stated that for each patient that goes untreated, the complications of lymphedema will increase the frequency of infections with the severity that does progress to life-threatening sepsis requiring intensive care hospitalizations. In addition, the comorbidities of pain, immobility, and limb dysfunction result in loss of work, loss of income, and depression often requiring pharmacological intervention.

In written comments, the HIAA stated that despite the lack of statistical data and the myriad treatment options, many insurers provide coverage for specific treatments including compression garments and antibiotics. HIAA stated that House Bill 383 establishes a one-size-fits-all-treatment mandate, when there is little evidence that persons diagnosed with lymphedema are being denied adequate coverage.

*g The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

*h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

In 2001, House Joint Resolution No. 524 designated March 6 and each succeeding year as Lymphedema D-Day in Virginia. The resolution stated that swelling caused by the accumulation of lymphatic fluid can lead to severe infection or loss of the use of limbs. Patients that are suffering from lymphedema must tolerate physical discomfort and disfigurement and endure the suffering caused by these symptoms. The resolution noted that lymphedema has no cure, and it can occur anytime. Patients diagnosed with lymphedema may experience physical, psychological, and financial hardship. The NLN sponsored Lymphedema D-Day to honor patients and to increase the awareness of the treatment and severity of this condition. The General Assembly encouraged the citizens of the Commonwealth to respect and support patients that are living and coping with this devastating condition.

## <u>FINANCIAL IMPACT</u>

*a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

No information was provided by either proponents or opponents that would suggest that the cost of treatments would increase or decrease in the next five years because of insurance coverage.

*b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.*

According to the ACS, untreated lymphedema can lead to serious problems. Coverage for the treatment of lymphedema might appropriately decrease the use of medical supplies and management, or both. ACS stated that early and proper treatment can prevent development of serious infections and costly follow-up medical visits. The appropriate use of treatment could possibly increase.

*c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

In written comments, an occupational therapist stated that the provision of timely and appropriate treatment for lymphedema can reduce or eliminate complications such as infection, reduce costs for health care insurers, relieve suffering, reduce disability and allow persons with lymphedema to re-enter the workforce. The therapist believes that withholding lymphedema treatment is shortsighted and economically unwise.

*d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.*

Coverage for the treatment of lymphedema is not expected to affect the number or types of providers of the treatment over the next five years.

*e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.*

An increase in the administrative expenses of insurance companies, in premiums, and in the administrative expenses for policyholders is anticipated because of the expenses associated with, among other things, policy redesign, form filings, claims processing systems, and marketing.

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.15 to $2.00 per month per standard individual policyholder and from $.02 to $5.53 per month per standard group certificate to provide the coverage required by House Bill 383. Insurers providing coverage on an optional basis provided cost figures of $.25 to $5.58 per month per individual policyholder and from $.25 to $3.98 per month per group certificate holder for the coverage required by House Bill 383.

*f. The impact of coverage on the total cost of health care.*

In written comments, the VAHP opposed House Bill 383 and stated that this bill prohibits calendar year or durational limitations on coverage for the treatment of lymphedema. The VAHP noted that this provision is problematic due to its capacity to negatively impact plans' ability to affordably price a product. The VAHP stated that the language in the original bill could complicate coverage for certain supplies. Pumps are currently being coded as durable medical equipment by the health plans. This legislation would prohibit that standard practice, therefore leading to complications in providing reimbursement for these devices.

In written comments, the Virginia Chamber of Commerce opposed additional mandates because the cost of health insurance is rising dramatically for all purchasers including large corporations, small businesses, and individuals. The Virginia Chamber of Commerce reported that government mandates were blamed for 15% of the rise in health care spending and currently account for more than one-fifth of the cost of a policy in Virginia.

In written comments, Trigon Blue Cross Blue Shield stated that mandates have the effect of making health care too costly for individuals and small business that are least able to afford health insurance. As the number of benefit mandates increase, along with the cost of insurance, small employers are less likely to offer health coverage to their employees.

## MEDICAL EFFICACY

*a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

The ACS submitted a study, entitled "Effective Treatment of Lymphedema of the Extremities", Archives of Surgery, April 1998. The study reported the results of a test, designed to define the immediate and long-term reduction for lymphedema patients following a complete decongestive physiotherapy (CDP). The CDP is a 2-phase noninvasive therapeutic regiment. The first phase consists of manual lymphatic massage, multi-layered inelastic compression bandaging, remedial exercises, and meticulous skin care. Phase 2 focuses on self-care by means of daytime elastic sleeve or stocking compression, nocturnal wrapping, and continued exercises. The study included 299 patients that were referred for evaluation of the upper and lower extremities for an average duration of 15.7 days. The lymphedema reduction rate averaged 59.1% after upper-extremity CDP and 67.7% after lower-extremity treatment. With an average follow up of 9 months, this improvement was maintained in compliant patients (86%) at 90% of the initial reduction for upper extremities and lower extremities. Noncompliant patients lost a part (33%) of their initial reduction. The incidence of infections decreased from 1.10 infections per patient per year to 0.65 infections per patient per year after a complete course of CDP.

*b. If the legislation seeks to mandate coverage of an additional class of practitioners:*

*1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

*2) The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

## EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

*a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.*

House Bill 383 addresses the medical need of treating individuals diagnosed with lymphedema. The benefit is consistent with the role of health insurance.

*b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.*

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.15 to $2.00 per month per standard individual policyholder and from $.02 to $5.53 per month per standard group certificate to provide the coverage required by House Bill 383. Insurers providing coverage on an optional basis provided cost figures of $.25 to $5.58 per month per individual policyholder and from $.25 to $3.98 per month per group certificate holder for the coverage required by House Bill 383.

*c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insured.

## RECOMMENDATION

The Advisory Commission voted unanimously (10 – 0) on January 8, 2003 to recommend that House Bill 383 be enacted as amended by Delegate Wardrup on December 2, 2002.

## CONCLUSION

The Advisory Commission believes that the amended bill minimizes the cost impact of the mandate on health care coverage. The Advisory Commission believes that the benefits provided by the mandate are significant and will likely result in a reduction in the complications of lymphedema and the costs associated with treating lymphedema.