REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR ARTIFICIAL LIMBS
House Bill 2552

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2003

[DATE]

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 2552 regarding a proposed mandate of coverage for Artificial Limbs.

Respectfully submitted,

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

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MANDATED HEALTH INSURANCE BENEFITS

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INTRODUCTION

The House Committee on Commerce and Labor referred House Bill 2552 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) for review during the 2003 Session of the General Assembly of Virginia. House Bill 2552 was introduced by Delegate R. Steven Landes.

The Advisory Commission held a public hearing on August 4, 2003 in Richmond, Virginia to receive public comments on House Bill 2552. In addition to the bill's patron, seven speakers addressed the proposal. A Medicaid Reviewer from the Virginia Department of Medical Assistance (DMAS), a prosthetist from the W.E. Hanger Company, a prosthetist from the Thomas G. Powell Orthopedic Company, and an eighteen-year-old constituent who is an amputee and college student at William and Mary, spoke in favor of House Bill 2552. A representative of the Virginia Association of Health Plans (VAHP), Virginia Chamber of Commerce (VCC), and Health Insurance Association of America (HIAA) spoke in opposition to the bill and provided written comments.

The Advisory Commission concluded its review on September 15, 2003.

SUMMARY OF THE PROPOSED LEGISLATION

House Bill 2552, as introduced, would add § 38.2-3418.14 to the Code of Virginia to require insurers to provide coverage for artificial limbs (arms and legs). These provisions would apply to all insurers proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and health maintenance organizations (HMOs) providing health care plans.

Section B bill defines "artificial limb" as a medically necessary prosthetic appliance prescribed as the result of the amputation of an arm or leg. The benefit must include coverage for the replacement of an artificial limb when medically appropriate, including, but not limited to, replacements required as a result of the insured's growth and normal wear and tear on an artificial limb. The benefit does not include replacement more frequently than once in a 12-month period. Section C requires that artificial limbs are not to be considered durable medical equipment for the purpose of coverage limits, coinsurance, or copayments and deductibles.

At the September 15, 2003 meeting of the Advisory Commission, Delegate Landes submitted an amendment to House Bill 2552. The amendment limits the proposal to artificial legs only. "Artificial leg" is defined as a medically necessary prosthetic appliance prescribed as the result of an above-the-knee amputation of a leg. The frequency with which an artificial leg could be replaced

remained the same at one replacement in a 12-month period and the requirement that artificial limbs not be considered durable medical equipment for the purpose of coverage limits, coinsurance, or copayments and deductibles did not change.

ARTIFICIAL LIMBS

According to the Center for Health Statistics in 1996, there were approximately 1.2 million persons living without a limb in the United States. Of the 1.2 million amputees, 86 percent have experienced a lower-limb amputation.[1] According to the 1998 Lower-Limb National Outcomes Study, 74 percent of amputees are transtibial (below-knee) amputees and 18.5 percent are transfemoral (above-knee) amputees. In 1994, the National Center for Health Statistics, Disability Report; Table 1 reported that approximately 199,000 persons in the U.S. were using an artificial limb, with the majority utilizing an artificial leg or foot (173,000). [2]

Approximately 6,000 upper extremity amputations (15% of major amputations) are performed annually in the United States.[3] Under ideal conditions, 70% of upper extremity amputees utilize prosthesis when other medical conditions are not a factor.

The Health Care Utilization Project National Inpatient Sample (HCUP-NIS), 1996 states that the number of new cases of limb loss is greatest among persons with diabetes. One out of every 185 persons diagnosed with diabetes undergoes amputation of a limb. Limb deficiency occurs in 1 in 3,846 live births in the U.S., or at a rate of 2.6 per 10,000 live births. Congenital upper limb deficiency occurs 1.6 times more often than lower limb deficiency.[4]

By the year 2010, the baby boom population will reach the ages of 46 to 64, enlarging the proportion at risk of diseases causing amputation. By the year 2020, the number of amputees in need of prostheses will increase by 47 percent. [5](Source: *O&P Business News.)*

MEDICAL EFFICACY

An amputee's functional success relates to the level of his amputation. Those with above-knee amputations ought to be less independent, or use their prostheses less, than those whose amputations are below the knee. A review of 157 patients with lower extremity amputations from a North Carolina hospital showed that all but 28 were fit with prostheses. Of the people who received prostheses, 88 used them to walk while 41 did not; 66% of those with trans-tibial (below-knee) amputations became functional prosthetic ambulators, as did 46% of those with trans-femoral (above-knee) amputations, but only 19 percent of those with bilateral amputations became functional.[6] (Moore, Barron, Hutchinson, et al., 1989).

Other studies indicate that pre-amputation function predicts success better than level of amputation. A prosthetic rehabilitation team in the Veteran's Administration (VA) system studied 95 adults with peripheral vascular insufficiency over three years. They used a seven-level functional grading system to rate patients' ambulation prior to amputation and found that 84 percent eventually walked within one functional level of their pre-amputation status. They concluded that "prosthetic use increased and the use of walking aids decreased with increased functional ambulation levels, but did not correlate with surgical levels."[7] (Pinzur, Littooy, Daniels, Arney, Reddy, et al., 1992, p.239). One Australian study of 200 amputees concludes that "any person previously walking [should] be considered for a trial of prosthetic walking."[8] (Penington, Warmington, Hull, & Freijah, 1992, p.774).

William C. Walker, MD, Associate Professor and Vice Chairman, Clinical Care Department, Physical Medicine and Rehabilitation, Medical Director, Brain Injury Rehabilitation Virginia Commonwealth University / Medical College of Virginia Campus, believes in the medical efficacy of prosthetics. He describes the benefits of a correctly prescribed and fitted prosthesis on several levels of personal outcomes. There is improved stability and energy efficiency of ambulation when focusing on impairment. When talking about one's disability, the result is improved community mobility and pursuit of "normal" activities, such as work and recreation. Regarding cosmesis, the benefit is improved body image and acceptance by others. Overall, combined with the psychological benefit, life satisfaction is generally improved. Michael Norton representing American Orthotic and Prosthetic in Richmond, VA stated that if prosthesis is utilized to increase the quality of life of a client, the client is less likely to have future problems associated with the medical condition.

The average prostheses can be expected to last at least 2 years with standard daily use. Dr. Jay Nogi of Medical College of Virginia-Virginia Commonwealth University, assigned to the Children's Hospital in Richmond, VA indicated that the younger children are in age, the more frequently the prosthesis is replaced due to wear and tear and growth. As children age and grow, the device is replaced every 2 to 3 years. Usually, upon reaching age 18, the device is replaced every 3 to 5 years. Adult replacements depend on the type of device, but, the typical replacement time is approximately one year to 2 ½ years. The more elite apparatus, those with electrical mechanisms, or new section methods for suspending prosthesis require more frequent revision. [9]

SOCIAL IMPACT

Ideally, the role of prosthesis is to replace lost physical functions, add mobility, and provide cosmetic, sensory, and expressive functions. Some experts assert that the costs of prosthesis include discomfort, damage to clothing, increased energy expenditure, decreased speed and endurance,

decreased lifting capacity, limited functional range of motion, maintenance costs, and low social acceptance.[10]

The number of new cases of limb loss is greatest among persons with diabetes, with 1 out of every 185 persons diagnosed with diabetes undergoing amputation of a limb. Limb deficiency occurs in 1 in 3,846 live births in the U.S., or at a rate of 2.6 per 10,000 live births. Congenital upper limb deficiency occurs 1.6 times more often than lower limb deficiency.[11] (Source: Health Care Utilization Project National Inpatient Sample (HCUP-NIS), 1996).

Table 1.0 Persons Living with Limb Loss, 1996*	
Age Group	Frequency
< 18 years	70,000
18 – 44 years	293,000
45 – 64 years	305,000
65 – 74 years	395,000
75+ years	223,000
Gender	
Male	893,000
Female	392,000
Race	
White	1,188,000
Black	98,000
3*Absence of extremity, excluding fingers and toes.	
DATA SOURCE: National Health Interview Survey, Vital Statistics Report, Series 10, No. 200.	

CURRENT INDUSTRY PRACTICES

The Bureau of Insurance (Bureau), in its capacity as staff to the Advisory Commission, surveyed 60 of the top writers of accident and sickness insurance in Virginia regarding House Bill 2552. Fifty companies responded by June 16, 2003. Thirteen indicated that they have little or no applicable health insurance business in Virginia, and, therefore, could not provide the information requested. Of the 37 respondents that completed the survey, 31 reported that they currently provide the coverage required by House Bill 2552.

One company qualified its coverage by indicating that replacement limbs would be covered if there was a physical change in the insured such that the limb could not be modified. Two companies stated that the need was required to be medically necessary. A third company provided coverage under a Durable Medical Equipment (DME) provision.

FINANCIAL IMPACT

Seven companies provided cost estimates to provide the coverage of House Bill 2552. Respondents to the Bureau of Insurance survey provided cost figures of between $.01 and $.45 per month per standard individual policy provide coverage for House Bill 2552. Cost figures were between $.01 and $.53 per month per standard group policy to provide coverage for House Bill 2552. Insurers providing estimates of coverage on an optional basis provided cost figures from $.36 to $2.23 per standard individual policy and from $.30 to $1.34 per month per group certificate.

Staff also spoke with Michael Norton representing American Orthotic and Prothetic in Richmond, VA. He indicated that prosthetic costs were based on patient activity level and necessary componentry. His business has consistently included orders for a low-tech/low activity below-the-knee prosthesis ranging in price from $3,000 to $3,500. A recreational below-the-knee prosthesis for a younger patient would range in price from $10,000 to $15,000 depending on the activity level. An above-the-knee prosthesis could range from $5,000 to $40,000 for a very active person if computerized componetry was used; however, justification would be required. A hip disarticulation with no computer componetry would range from $5,000 to $7,000. An above-the-elbow device with a harness would cost approximately $5,000. A conventional body part utilizing myoelectrical componentry with a hand terminal would range in price from $4,500 to $12,000.[12]

The exact impact of House Bill 2552 for insurers licensed to write business in Virginia, and those that cover prosthetic devices is not known. A comprehensive analysis of the unit cost issue was unavailable from any resource.

MEDICARE REIMBURSEMENT

In the United States, Medicare is the largest financial resource for prosthetic care. According to the Healthcare Common Procedure Coding System (HCPCS), prostheses are covered when furnished incident to physicians' services or on a physician's order**.** Accessories (e.g. stump stockings for the residual limb, harness (including replacements) are also covered when these appliances aid in or are essential to the effective use of the artificial limb.[13]

When submitting a prosthetic claim for knees, feet and ankles, components must be submitted with modifiers K0 - K4, indicating the expected patient functional level. The expectation of functional ability information must be clearly documented and retained in the prosthetist's records.

Medicare uses classification codes called Level II Modifiers that qualify standards related to components and procedures appropriate for each amputation function level. Michael Norton, American Orthotic and Prothetic in Richmond, VA stated that the "K-Modifiers" are useful to him in demonstrating that a service or technology is sound, and will enhance a patient's potential functionality or independence. Mr. Norton stated that it has been his experience that the normal, socially active individual is categorized at the K3 level.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners (NAIC), the states of Maryland and Colorado currently mandate coverage for prosthetic devices (artificial devices to replace an arm or leg) and orthotic braces.

REVIEW CRITERIA

SOCIAL IMPACT

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

Testimony presented by the Virginia Association of Health Plans (VAHP) indicated that there is no single source of readily available statistics and data on prevalence and problems associated with limb loss. According to the Center for Health Statistics in 1996, there were approximately 1.2 million persons living without a limb in the United States. In 1994, the National Center for Health Statistics, Disability Report; Table 1 reported that approximately 199,000 persons in the U.S. were using an artificial limb, with the majority utilizing an artificial leg or foot (173,000).

A research study of amputations performed in the United States in 1991 indicate that *90-96% of* all amputations in the U.S. involve lower limbs.[14]

- 32,000 AK (transfemoral)
- 22,000 BK (transtibial)
- 10,000 transmetatarsal

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

The Bureau of Insurance (Bureau), in its capacity as staff to the Advisory Commission, surveyed sixty of the top writers of accident and sickness insurance in Virginia regarding coverage for artificial limbs. Fifty companies responded by June 16, 2003. Thirteen indicated that they have little or no applicable health insurance business in Virginia, and, therefore, could not provide the information requested. Of the 37 respondents that completed the survey, 31 reported that they currently provide the coverage required by House Bill 2552.

One company qualified its coverage by indicating that replacement limbs would be covered if there was a physical change in the insured such that the limb could not be modified. Two companies stated that the need was required to be medically necessary. A third company provided coverage under a Durable Medical Equipment (DME) provision.

The VAHP testified that each of its 25-member health plans, which together provide coverage to 3.9 million Virginians, provide coverage for medically necessary prosthetic devices.

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.

Specific information was not presented on the number of people that have not been treated due to of a lack of coverage.

Proponents argue that it is reasonable to assume that some patients may need several prosthesis during their lifetime. As a child grows and the body changes, or with weight gains and losses a properly fitting prosthesis is essential. Insurance limitations restrict the consumer from accessing appropriate health providers, appropriate technology and adequate insurance reimbursement.

Opponents contend that there are a number of resources available to assist individuals in need of artificial limbs. The Virginia Department of Rehabilitative Services and a number of non-profit organizations are cited as potential resources.

The average prostheses can be expected to last at least 2 years with standard daily use. Dr. Jay Nogi of Medical College of Virginia-Virginia Commonwealth University assigned to the Children's Hospital in Richmond, VA indicated that the younger children are in age, the more frequently the prosthesis is replaced due to wear and tear and growth. As children age and grow, the device is replaced every 2 to 3 years. Usually, upon reaching age 18, the device is replaced every 3 to 5 years. Adult replacements depend on the type of device, but, the typical replacement time is approximately one year to 2 ½ years. The more elite apparatus, those with electrical mechanisms, or new section methods for suspending prosthesis require more frequent revision.

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.

Proponents contend there is disparity in prosthetic reimbursement throughout the insurance industry. There is no fixed or universal policy from one company to another, and little to no average reimbursement exists within the industry. In many cases, coverage is limited to inadequate durable medical equipment (DME) limits as little as $1,000, lifetime limits, or caps on total payments, leaving amputees unable to afford prosthetic devices. As such, the amputee must rely on the provisions of the manufacturer or the insurance carrier.

Opponents contend that coverage is generally available. The market may provide the coverage; however the employer or individual must make the determination to purchase the coverage, which usually takes the form of a rider and bears additional cost. Also, there are a number of resources available to assist individuals in need of artificial limbs.

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

Including partial foot amputations 91.7 percent of all amputations concern the lower-limb. Of the 8.3 percent of upper-limb amputees 4.4 percent are below-elbow and 2 percent are above-elbow. Sixty-eight (68) percent of all amputees are aged 51 or older. People ages 60-70 represent the largest population at 28 percent, while those 51-60 represent 18 percent of

amputees. Seventy-five (75) percent of amputations result from disease, 22 percent from trauma, and 3 percent from congenital conditions.[15]

The number of new cases of limb loss is greatest among persons with diabetes, with 1 out of every 185 persons diagnosed with diabetes undergoing amputation of a limb. Limb deficiency occurs in 1 in 3,846 live births in the U.S., or at a rate of 2.6 per 10,000 live births. Congenital upper limb deficiency occurs 1.6 times more often than lower limb deficiency

According to Joshua Sundquist, an amputee and proponent of House Bill 2552, there are approximately 5,000 amputees in Virginia utilizing prosthetic limbs. The Virginia Department of Medicaid Assistance (DMAS) approved 1,524 prosthetic devices in 2002.

By the year 2010, the baby boom population will reach the ages of 46 to 64, enlarging the proportion at risk of diseases causing amputation. By the year 2020, the number of amputees in need of prostheses will increase by 47 percent.[16] (Source: *O&P Business News.)*

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

Two prosthetists spoke in support of House Bill 2552. Each cited examples of patients' inability to purchase necessary prostheses due to insurance limitations and inadequacies. One prosthetist presented the argument that classifying custom-made prostheses as durable medical equipment (DME) is an inadequacy. The prosthetic device does not meet the criteria of DME as a prosthetic device cannot be recycled because specific componentry is used based on the individual patient's weight, activity level, profession, etc. An argument for insurance coverage limitation is based on the amount of the DME provision. If the major portion of the DME provision is used for canes, crutches or walkers, the remaining balance is insufficient for prostheses.

Written comments from the VAHP state that there are a number of resources available to assist individuals in need of an artificial limb. Each VAHP member plan provides coverage, in some form, for medically necessary prosthetic devices.

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.

No information or relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of this mandated benefit was presented during this review.

FINANCIAL IMPACT

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

Opponents argue that if prostheses were prohibited from being classified as DME, the coverage for prostheses would fall under a standard benefit package, and rates would increase. Also, a provision designed to limit the member's cost share responsibility is in direct opposition to market trends. The VAHP indicated that health care benefits costs have increased an average of 18% in 2003 for more than 90% of employers, resulting in a 13% increase in employee shared cost.

The Virginia Chamber of Commerce expressed in written comments that mandates will add to the cost of providing coverage and will cause employers to reassess how or if health insurance can remain a benefit to employees.

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

Proponents anticipate that the proposed mandate will increase the appropriate use of artificial limbs, specifically artificial legs. As a child or young amputee continues to grow, the growth changes will allow for replacement limbs and the use of new technology. Utilizing replacement limbs would provide a greater opportunity for individual mobility and productivity.

Opponents expressed concern that this legislation would increase the inappropriate use of expensive, technologically advanced prostheses.

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

Proponents believe the insurance carriers could save money by increasing prosthetic reimbursement. Statistics indicate that people who do not wear prostheses are at a higher risk of diabetes, obesity, depression cardiovascular disease, bone loss and some forms of cancer, and other secondary conditions. These comobidities and other conditions cost insurance carriers more than the prostheses reimbursement.

Proponents make the argument that if a prosthesis is utilized to increase the quality of life for a client, the client is less likely to have future problems associated with the medical condition, and will submit a lower number of subsequent claims.

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.

The number and type of providers of the mandated service are not expected to increase 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.

Respondents to the Bureau of Insurance survey provided cost figures of between $.01 and $.45 per month per standard individual policy and between $.01 and $.53 per month per standard group policy to provide coverage for House Bill 2552. Insurers estimates of providing coverage on an optional basis provided cost figures from $.36 to $2.23 per standard individual policy and from $.30 to $1.34 per month per group certificate.

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

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

The total cost of health insurance is not expected to be significantly affected.

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.

Proponents contend that this legislation seeks to improve a patient's quality of life by allowing him to become more productive and active. The role of the prosthesis is to replace lost physical functions, add mobility, and provide cosmetic, sensory, and expressive functions. Michael Norton representing American Orthotic and Prosthetic in Richmond, VA stated that if a prosthesis is utilized to increase the quality of life, the client is less likely to have future problems associated with the medical condition.

William C. Walker, MD, Associate Professor and Vice Chairman, Clinical Care Department, Physical Medicine and Rehabilitation, Medical Director Brain Injury Rehabilitation Virginia Commonwealth University/Medical College of Virginia Campus believes in the medical efficacy of prosthetics. He describes the benefits of a correctly prescribed and fitted prosthesis on several levels of personal outcomes. There is improved stability and energy efficiency of ambulation when focusing on impairment. When talking about one's disability, the result is improved community mobility and pursuit of "normal" activities such as work and recreation.

The cosmetic benefit is improved body image and acceptance by others. Overall, combined with the psychological benefit, life satisfaction is generally improved even if costs include discomfort, damage to clothing, increased energy expenditure, decreased speed and endurance, decreased lifting capacity, limited functional range of motion, maintenance costs, and low social acceptance.

A review of 157 patients with lower extremity amputations from a North Carolina hospital showed that all but 28 were fit with prostheses. Of the people who received prostheses, 88 used them to walk while 41 did not; 66% of those with trans-tibial (below-knee) amputations became functional prosthetic ambulators, as did 46% of those with trans-femoral (above-knee) amputations, but only 19 percent of those with bilateral amputations became functional ambulators (Moore, Barron, Hutchinson, et al., 1989).

Other studies indicate that pre-amputation function predicts success better than level of amputation. A prosthetic rehabilitation team in the Veteran's Administration (VA) system studied 95 adults with peripheral vascular insufficiency over three years. They used a seven-level functional grading system to rate patients' ambulation prior to amputation and found that 84% eventually walked within one functional level of their pre-amputation status.

They concluded that "prosthetic use increased and the use of walking aids decreased with increased functional ambulation levels, but did not correlate with surgical levels."

Opponents recognize that loss of a limb can create a physical, emotional, and financial challenge for the amputee. The VAHP acknowledged that issues pertaining to artificial limbs are complicated. Prosthetics and orthotics is a difficult field to assess since most outcomes are client-specific and many clinical decisions are based on the clinician's experience (and not on scientific principles).

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.

Proponents argued that House Bill 2552 addresses the medical needs of amputees who have lost one or more legs or who are in need of replacement prostheses. These consumers are being forced to live without the necessary equipment that would enable them to become active and viable members of society due to insurance limitations. Proponents contend that such limitations and inadequacies could lead to delayed recovery or financial difficulties, and, in other cases, they served as impediments to successful long-term employment.

Opponents argued that this bill does not consider the impact of technological advancements, as amputees have a wide variety of prosthetic choices. Also, there is no single resource that can readily provide pertinent data into the incidences and consequences of limb loss and limb deficiency.

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

Proponents believe that the need for coverage outweighs the costs of mandating the benefit for all policyholders because it costs less to provide coverage for prosthetic reimbursement than to treat comobidities or secondary conditions.

Opponents believe that mandating benefits is not good public policy and can have the ultimate effect of making health care too costly for individuals and small businesses least able to afford it.

The VAHP and the Virginia Chamber of Commerce are opposed to additional mandated benefits because of the effect of incremental premium increases, and the potential to reduce the number of individuals that have the benefits of health insurance.

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 individual coverage, the market may provide the coverage; however the individual must make the determination to purchase the coverage, which usually takes the form of a rider and bears additional cost. 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 insureds.

RECOMENDATION

The Advisory Commission voted on September 15, 2003, to recommend that House Bill 2552 not be enacted (11-yes, 0-No).

CONCLUSION

The Advisory Commission discussed the disparity of mandating coverage for a specific limb and was concerned with the effectiveness of the public policy. The Advisory Commission concluded that coverage for artificial limbs would impact a very small population and a mandate is not warranted at this time.

[1]National Health Interview Survey, 1996 by the Office on Disability and Health, National Center for Environmental Health, Centers for Disease Control and Prevention, Atlanta Georgia.

[2] National Center for Health Statistics, Disability Report; Table 1,1994.

[3],[10] Roger E. King, SPT. "Factors Responsible for the Prosthetic Success of Traumatic Upper Extremity Amputees," School of Occupational Therapy and Physical Therapy, University of Puget Sound, 1997

[4] Healthcare Cost and Utilization Project (HCUP), 1988-2000: A Federal-State-Industry Partnership in Health Data. February, 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/data/hcup/hcup-pkt.htm

[5] Judith Otto, "In Search of Tomorrow's O&P Practitioner," The O&P Edge, September, 2002, www.oanp.com.

[6] Moore, T.J., Barron, J., Hutchinson, F, et al. (1989). Prosthetic usage following major lower extremity amputation. *Clinical Orthopedics and Related Research, 238*, 219-224.

[7] Pinzur, M.S., Littooy, F., Daniels, J., Arney, C., Reddy, N.K., Graham, G., & Osterman, H. (1992). Multidisciplinary preoperative assessment and late function in dysvascular amputees. *Clinical Orthopedics and Related Research, 281*, 239-243.

[8] Penington, G., Warmington, S., Hull, S., & Freijah, N. (1992). Rehabilitation of lower limb amputees and some implications for surgical management. *Australian & New Zealand Journal of Surgery, 62*, 774-779.

[9] Dr. Herbert W. Park. Testimony, Public Hearing, Special Advisory Commission on Mandated Health Insurance Benefits, August 4, 2004.

[11] Healthcare Cost and Utilization Project (HCUP), 1988-2000: A Federal-State-Industry Partnership in Health Data. February, 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/data/hcup/hcup-pkt.htm

[12] Michael Norton, Prosthetist, Telephone conversation, July 9, 2003.

[13] Lower Limb Prosthesis, HCPCS Codes, http://www.medi-supply/Merchant2/lower%20limb%20prosthesis%20coverage.htm

[14] Mueller, M.J., Allen, B.T., & Sinacore, D.R. (1995). Incidence of skin breakdown and higher amputation after transmetatarsal amputation: Implications for rehabilitation. *Archives of Physical Medicine and Rehabilitation, 76,* 50-54.

[15] Prosthetics Information Page, Northwestern University Prosthetics-Orthotics Center (http://www.nupoc.northwestern.edu/pros info.shtml).

[16] Judith Otto, "In Search of Tomorrow's O&P Practitioner," The O&P Edge, September, 2002, www.oanp.com.