

COMMONWEALTH OF MASSACHUSETTS

MANDATED BENEFIT REVIEW

**REVIEW AND EVALUATION OF PROPOSED LEGISLATION
TO MANDATE COVERAGE FOR CERTAIN PROSTHETIC DEVICES:**

H. 837

**PROVIDED FOR:
THE JOINT COMMITTEE ON FINANCIAL SERVICES**

**DIVISION OF HEALTH CARE FINANCE AND POLICY
COMMONWEALTH OF MASSACHUSETTS
APRIL, 2005**

EXECUTIVE SUMMARY

This report was prepared by the Division of Health Care Finance and Policy pursuant to the provisions of M.G.L. c. 3, § 38C. This section requires the Division to evaluate the impact of a mandated benefit bill referred by legislative committee for review and to report to the referring committee. The Division was requested to evaluate a bill pertaining to health insurance coverage for prosthetic devices.

Proposed bill H. 837 would require “all health insurers,” except Medicare, MassHealth and other governmental programs, to provide coverage for all enrollees having a principal place of employment within the Commonwealth for certain prosthetic devices that are medically necessary. The mandate stipulates coverage be comparable to or greater than the coverage level of Medicare, which currently pays 80% of the allowable charge for a prosthetic after the \$100 Part B deductible is met by the enrollee. The bill also mandates that all plans cover repairs and replacement of prosthetic devices.

We received coverage information from the four Massachusetts commercial insurers that insure the majority of Massachusetts residents under age 65. Currently, all Massachusetts insurers provide some level of coverage for prosthetic devices, ranging from unlimited coverage to a maximum annual limit of \$1,500 per member. This coverage is sometimes under the durable medical equipment (DME) category, which means that the annual limit applies to the total of any and all DME items purchased by the patient. This mandate will not affect plans currently offering unlimited coverage for prostheses. Compass Health Analytics Inc. estimates that over the next five years the average cost for this mandate would range from \$5.3 million to \$9.0 million, with a mid-range estimate of \$6.5 million; premiums would increase by an average of \$0.41 over the same time frame. Most insurers already cover repairs and replacements; however, as coverage levels for repairs and replacements vary across plans, the cost of providing this service would similarly affect insurers who do not currently offer coverage that is at least equivalent to that of Medicare.

TABLE OF CONTENTS

SECTION	PAGE
EXECUTIVE SUMMARY	0
INTRODUCTION	1
OVERVIEW OF PROPOSED LEGISLATION	1
BACKGROUND	2
MEDICAL EFFICACY	2
ORGANIZATIONS THAT SUBMITTED INFORMATION TO DHCFP	3
CURRENT COVERAGE LEVELS AND COST OF PROSTHETIC DEVICES.....	3
FINANCIAL IMPACT OF MANDATE.....	5
LEGISLATIVE ACTIVITY IN OTHER STATES.....	7
ENDNOTES	8
APPENDIX I: ACTUARIAL ASSESSMENT (COMPASS ANALYTICS)	
APPENDIX II: TESTIMONIALS SUBMITTED	

INTRODUCTION

Most individuals experiencing the absence or loss of a limb have the potential to attain a high degree of function and a satisfying quality of life with the use of a prosthesis that can assist with activities of daily living. A small number of individuals may not be candidates for prostheses or are not able to tolerate a prosthetic device.

OVERVIEW OF PROPOSED LEGISLATION

The Joint Committee on Insurance requested that the Division of Health Care Finance and Policy (DHCFP) review and evaluate this bill pertaining to health insurance coverage for prosthetic devices:

- H. 837 *An Act Providing Health Care Coverage for Certain Prosthetic Devices*

The proposed bill would require all health insurers to provide coverage similar to Medicare for medically necessary prosthetic devices that adequately meet the medical needs of enrollees, as determined by a treating physician.

The bill also proposes coverage for medically necessary repairs and replacements of prosthetic devices subject to copayments and deductibles. The proposed bill does not explicitly state its applicability to non-group plans; however, the actuarial estimates within this analysis have included non-group plan enrollees. Further, while the legislation does not state this explicitly, the DHCFP analysis is restricted to external prostheses of arms and legs.

Although the bill includes reference to a clause of Medicare's law that sets provider payments, DHCFP was unable to confirm whether the legislation is intended to stipulate provider rates, which would be a departure from usual practice. Since insurer-negotiated provider rates are proprietary, and Medicare provider rates are not available to DHCFP the Compass actuarial analysis did not account for a change in provider rates.

BACKGROUND

A prosthesis is an artificial device that replaces, in whole or in part, a body part—in this case, an arm or a leg. Prosthetic devices are used by individuals who lose a limb due to amputation (limb loss), or by individuals with congenitally missing or malformed limbs (limb deficiencies). In the United States, there are approximately 135,000 new amputees each year and limb deficiencies occur in 26 of 100,000 live births.¹ Seventy-five percent of amputations done in the United States are due to diseases, primarily diabetes, vascular diseases, and cancer. Most of the remainder is trauma related.²

Limb loss may occur in individuals of any race, ethnicity, or background without regard to geographic location or economic level. In 1996, there were approximately 12 million people (490 persons for every 100,000 people) living with the absence of a limb in the United States.³ Although limb loss is experienced among all ages, the highest rate is among people ages 65 and older.⁴

Currently, both Medicare and Medicaid provide prosthetic device coverage to their beneficiaries. Medicare covers 80 percent of the allowable charge of the device, and the patient is responsible for the remaining 20 percent as their coinsurance. The beneficiary must also pay an annual deductible of \$100 before Medicare part-B coverage begins for any covered service, not just prostheses. Medicare also covers replacements (every five years), repairs and adjustments. The state's Medicaid program provides complete prosthetic coverage to its enrollees in the following Medicaid plans: MassHealth Standard, MassHealth Basic, MassHealth CommonHealth, MassHealth Family Assistance and, MassHealth Health Essential. In addition, families at certain income levels with children in need of prosthetic devices have the option to buy into MassHealthCommonHealth for their child's coverage. Replacements are covered when determined medically necessary by the physician.

Traditionally, all plans have offered some form of prosthetic coverage as part of the durable medical equipment (DME) allowance, an annual capped benefit within most health policies. Currently, some plans offer prosthetic coverage that is not part of DME; such coverage varies in its dollar limit (see discussion on page 4).

MEDICAL EFFICACY

DHCFP is charged with reporting the following: 1) the expected impact of the benefit on the quality of patient care and the health status of the population, and 2) the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services, or *not* providing the treatment or service.

The loss of an anatomical part, such as a limb, usually results in functional disability for the person and can lower one's self-image with significant psychological implications. For most people, prostheses help restore functional ability and independence. One study⁵ examined the relationship between body image and physical activity, and concluded that there was a positive association between regular participation in physical activity and body image among lower-limb amputees.

Studies suggest that prosthesis use and younger age at the time of amputation are more likely to influence employment.⁶ Between 70 percent and 90 percent of amputees return to some work sometime after their injury.

ORGANIZATIONS THAT SUBMITTED INFORMATION TO DHCFP

DHCFP developed a survey for members of the Massachusetts Association of Health Plans (MAHP) to distribute to its members and to Blue Cross Blue Shield. MAHP returned the completed surveys to DHCFP on behalf of MAHP's member health plans as did Blue Cross Blue Shield. The Massachusetts Society of Orthotics and Prosthetics supplied the diagnostic and procedural code numbers for the treatments referred to under this legislation. The Society also submitted a variety of information and statistics to DHCFP supporting passage of this mandate.

CURRENT COVERAGE LEVELS AND COST

Table 1 (below) displays the survey results from the four Massachusetts health plans who responded to our survey. All plans currently offer some form of coverage for prosthetic devices. One plan offers coverage for prosthetic devices only as part of members' durable medical equipment benefit. All other plans provide various forms of coverage ranging from 100 percent to a limit of \$1,500 per year, depending on the health plan selected by the employer, if a group plan. The insurers state that coverage is provided for the "most adequate prosthesis model that meets a patient's needs."

All plans cover repairs and replacements; one plan has a minimum period, which must elapse before a replacement is allowed. Coverage for repairs in the four plans surveyed is applied to the members' DME if prosthetic coverage is part of the member's DME.

The Office of Patient Protection has received two appeals of denial of some aspect of coverage for a prosthetic device. Both members requested prosthetic devices with a greater number of features than the plan approved. The request for prosthesis was not disapproved altogether by the plan, rather the prosthetic model requested by the enrollee was denied.

TABLE 1: HEALTH PLAN RESPONSES ON COVERAGE LEVELS AND COST

No	Questions	Plan 1	Plan 2	Plan 3	Plan 4
1	<i>Coverage part of DME</i>	No	Yes	Varies; For most plans coverage is not part of DME	Varies; employer group chooses how prosthetics will be covered
2	<i>Annual dollar limit</i>	No annual dollar limit for group plans \$1,500 annual limit for non-group plans	\$1,500-Unlimited	Limit of \$1,500 or 20% coinsurance, but most plans offer 100% coverage	Limit under DME is \$1,500 to unlimited per CY. Limit for non-DME coverage (if opted) varies by product and group. ^a
3	<i>Coverage limitations</i>	Coverage for least expensive prosthesis	Coverage for least expensive prosthesis ^b	Limited number of services/components depending on the item	Certain prosthetic devices may require authorization
4	<i>Are repairs covered?</i>	Yes	Yes	Yes	Yes
5	<i>Does the cost of repair come under DME coverage?</i>	No	Yes	Yes, if prosthetic coverage is part of DME ^c	Varies; employer group chooses how prosthetics will be covered
6	<i>Annual dollar limit for repairs, if not covered under DME</i>	No	-	N/A	Repairs for prosthesis is not broken out as a separate benefit in the evidence of coverage (included within annual dollar limit described above in 2)
7	<i>Do you impose a minimum period of time that must pass before you pay for replacement</i>	No (applies to both children and adults)	No (applies to both children and adults)	Every five years for replacements (applies to both adults and children)	If reviewed by an authorized reviewer, considered on a case by case basis
8	<i>Do you have contractual relations with prosthetic makers</i>	No ^d	Yes	No	Yes
9	<i>In the last 2 years, how many appeals were received</i>	4	12	No appeals filed	3
10	<i>Outcome of those appeals</i>	Claims were approved	10 denials were upheld; one case was withdrawn and closed	N/A	All 3 denied on appeal

^a \$0 – unlimited in HMO products; \$5,000 CY maximum with 80/20 coinsurance is an option under the PPO plans, although employer group may choose other CY maximums or coinsurance arrangements.

^b No coverage for spare limb prosthesis. Specialized prostheses required for occupational purposes, or for use in sports, are not covered. Prosthetics required for cosmetic purposes are covered only in limited circumstances.

^c If separate coverage is available for prosthetic devices, it would be charged under that benefit.

^d Currently, BCBS reimburses prosthetic suppliers participating in their network the same fee for covered services.

FINANCIAL IMPACT OF MANDATE

Compass Health Analytics performed an actuarial analysis to determine what effect this mandate would have on health insurance premiums. Please refer to Appendix I for Compass's entire report.

DHCFP is required by Section 3 of Chapter 300 of the Acts of 2002 to answer the following questions:

1. To what extent will the proposed insurance coverage increase or decrease the cost of the treatment or service over the next five years?

Currently, most health plans offer some kind of coverage for prosthetic devices, ranging from 100 percent to a maximum of \$1,500 per member per year. The proposed benefit, if passed, would require all health plans to provide coverage equivalent to Medicare. Compass Inc. estimates that this would cost an average of \$6.5 million in the first five years. The bill also mandates that all plans cover repairs and replacement of prosthetic devices. Most insurers already cover repairs and replacements; however, as coverage levels vary across plans the cost of providing this service would increase for insurers who do not currently offer coverage equivalent to that of Medicare.

According to an internet survey, the costs of prosthetic devices vary from a minimum of \$3,000 for an arm to a maximum of \$52,000 for a body-powered above the knee prosthetic.⁷ The bill stipulates that coverage be provided for the most appropriate medically necessary model that meets the medical needs of the individual "as determined by the physician." If this clause were interpreted to prohibit insurers from influencing the choice of device, then the average per patient cost of providing this service would be 30 percent higher over the first five years than if insurers *were* allowed to influence the choice of device. In the future, as newer, more technologically advanced devices become available, the cost of providing this benefit may increase further.

2. To what extent will the proposed coverage increase the appropriate or inappropriate use of the treatment or service over the next five years?

Since the majority of limb loss occurs in individuals who are over age 65, three major insurers reported that only about 500 members used this benefit in the last two years. In addition, while there may be some pent up demand to upgrade prostheses, there's probably little, if any, pent up demand awaiting this mandate in order to obtain one in the first place. Even in plans that don't currently pay the entire cost, members who need a prosthesis probably supplement their insurance coverage out of pocket.

Compass estimates utilization to increase in the first few years of coverage, but any subsequent increase is estimated to be negligible. The first-year increase in utilization is estimated to be 10 to 25 percent overall. Individuals currently in plans offering only limited coverage would be able to afford improved prostheses, or save some out-of-pocket costs with the passage of this mandate.

Further, requests for devices with a greater number of features or technologically advanced components than deemed necessary by a physician would be limited if the mandate were interpreted to allow insurers to influence the choice of device.

3. *To what extent will insurance coverage affect the number and types of providers of the mandated treatment or service over the next five years?*

Currently, most insurers offer coverage for prosthetic devices. The number of new people who would use this benefit if the mandate were passed would be small; however the types of prostheses they utilize might increase in complexity, but should not cause an increase in the need for prosthetic device providers over the next five years.

4. *To what extent will the mandated treatment or service serve as an alternative for more expensive or less expensive treatments or services?*

There are no alternatives to prosthetic devices for individuals experiencing limb loss. Given the wide range in costs of prosthetic devices, opponents of this bill are concerned that the prosthesis ordered by a member's physician be the most appropriate and least expensive prosthesis that would adequately meet the member's needs. If the mandate is interpreted to allow insurers, in addition to the treating physician, some influence in the choice of device, the impact on premiums might not be as significant as if the choice of prosthesis is left solely to the physician and patient.

5. *What are the effects of the mandated benefit on the cost of health care, particularly the premium, administrative expenses, and indirect costs of large and small employers, employees, and non-group purchasers?*

Since the majority of large employers are self-insured, this mandate would disproportionately affect small employers and non-group purchasers. Small employers now have some flexibility to choose a prosthetic benefit to meet their budget and their employees' perceived needs. Currently, the average annual cost per plan member for prosthetic devices is higher in plans that fully cover them than in plans that limit them, roughly \$1.78 versus \$0.83 per member per year. Compass estimates that passage of this bill would result in an average annual premium of \$0.41 per member for the next five years, but would disproportionately affect plans offering the least coverage currently (unless the higher benefit plans have attracted a greater number of individuals needing prostheses).

6. *What are the potential benefits and savings to large and small employers, employees, and non-group purchasers?*

In plans where employees have limited coverage due to high cost sharing, it is possible that members may have opted for a very basic device, which may not be useful in their work, but is used purely for appearance. As a result, the option to have a more affordable and higher quality prosthesis may enable an employee to return to work more quickly than otherwise and increase productivity, which would benefit the employer as well as the employee. Non-group purchasers

might also benefit from more generous coverage, but at a higher premium cost. This mandate would not affect the many large employers who are self-insured unless they choose to adopt this standard.

7. *What is the effect of the proposed mandate on cost-shifting between private and public payers of health care coverage?*

The impact of the proposed mandate on costs savings to Medicaid is difficult to predict. Individuals, specifically children, eligible for both private health insurance and MassHealth might not necessarily switch to private insurance with a more generous prosthetic benefit. If they have other significant health needs in addition to needing a prosthetic device, MassHealth might still provide the best comprehensive coverage for no or low cost (low cost if they qualify to buy into the program) for their overall health needs. However, there may be individuals who would accept offered private health insurance if the prosthetic benefit were expanded.

8. *What is the cost to health care consumers of not mandating the benefit in terms of out-of-pocket costs for treatment or delayed treatment?*

Limbs can cost from a minimum of \$3,000 to an average of \$10,000 to \$15,000 for a person paying out of pocket.⁸ Enrollees with limited coverage currently would have to pay some of the cost of the prosthesis out of pocket, which may cause a limited number of individuals to delay obtaining one, limiting their functionality and productivity. Some individuals who cannot afford to contribute out of pocket may also receive financial assistance through not-for-profit organizations, other sources, or apply for MassHealth.

To delay or forgo a prosthesis would not be in the best interest of an individual experiencing limb loss as a prosthesis enables one to be more independent and perform activities of daily living.

9. *What is the effect on the overall cost of the health care delivery system in the Commonwealth?*

This mandate would most likely shift some costs (for prostheses that cost more than an enrollee's allotted prosthetic allowance) currently borne by individual patients to insurers, and ultimately, employers. Costs to the system will also increase to the extent that enrollees upgrade their prostheses as a result of better coverage.

LEGISLATIVE ACTIVITY IN OTHER STATES

As of 2004, the National Conference of State Legislatures reported that four states have mandated coverage for prosthetic devices. These four states are Colorado, Maine, Maryland and New Hampshire. All four states statutes specify coverage equivalent to Medicare.

ENDNOTES

¹ Amputee Coalition of America. Accessible at www.amputee-coalition.org. Accessed on November 23, 2004.

² Handbook of Disabilities. 2001. University of Missouri. Accessible at <http://www.rcep7.org/projects/handbook>. Accessed on November 23rd, 2004.

³ Limb Loss Research & Statistics Program. Accessible at www.amputee-coalition.org.

⁴ Amputee Coalition of America. Accessible at http://www.amputee-coalition.org/fact_sheets/limbloss_us.html. Accessed on March 9th, 2005.

⁵ Wetterhahn KA, et al. 2002. Effect of participation on physical activity on body image of amputees. American Journal of Physical Medical Rehabilitation 81(3): 194-201.

⁶ Davidson J. 2002. A survey of the satisfaction of upper limb amputees with their prostheses, their lifestyles, and their abilities. Journal of Hand Therapy 15-62-70.

⁷ United Spinal Association. 2005. Spare parts: The uses and challenges of prosthetics. Orbit 2(2). Available at <http://www.unitedspinal.org/>. Accessed on March 9, 2005.

⁸ An internet survey.

**Actuarial Assessment of Massachusetts House Bill No. 376
Mandating Coverage for Certain Prosthetic Devices**

Prepared for

**Division of Health Care Finance and Policy
Commonwealth of Massachusetts**

Prepared by

Compass Health Analytics, Inc.

January 31, 2005



**Actuarial Assessment of Massachusetts House Bill No. 376
Mandating Coverage for Certain Prosthetic Devices**

Table of Contents

<u>Executive Summary</u>	1
<u>Proposed Legal Requirement</u>	2
<u>Overview of Impact Calculation</u>	2
<u>Discussion of Major Assumptions</u>	3
<i><u>Insured Population</u></i>	3
<i><u>Definition of Prosthesis</u></i>	4
<i><u>Current Limb Prostheses Costs for Insured Populations</u></i>	4
<i><u>Previous Self-selection and Physician Discretion in Treatment</u></i>	5
<i><u>First-year Demand</u></i>	5
<i><u>Medicare Standards for Copayments and Fees</u></i>	6
<i><u>Calculation of Premium Costs</u></i>	6
<i><u>Impact on Individual Plans</u></i>	7
<u>Results</u>	7
<u>Exhibits</u>	8
<u>Appendices</u>	11
<i><u>Development of Population Estimates</u></i>	12
<i><u>Development of Administrative Cost Estimates</u></i>	15

Actuarial Assessment of Massachusetts House Bill No. 376 Mandating Coverage for Certain Prosthetic Devices

Executive Summary

Massachusetts House Bill No. 376 would require insurers to “provide coverage for prosthetic devices that equals the coverage provided for such devices under the federal laws providing health insurance to the aged and disabled.” Compass Health Analytics, Inc. (“Compass”) was engaged by the Commonwealth’s Division of Health Care Finance and Policy (“the Division”) to develop an actuarial assessment of the likely increased healthcare costs resulting from the proposed mandate over the next five years. The results are based on analysis using data provided by the Division to Compass.

It appears that all people insured by commercial health plans in Massachusetts currently have some form of coverage for prosthetic devices and associated repairs, but that coverage varies widely. Some plans cover the devices fully (subject to various deductibles, copayments, etc.), while others set a limit that can be as low as \$1500 per year or less¹.

The key data that drive the estimate of the impact of the mandate are: (i) the current mix of prosthesis benefits across the Massachusetts insured population, and (ii) the current costs for prosthetic devices for plan populations with various levels of benefits. The Division provided Compass with summarized claims data from most major insurers in the Commonwealth, from which we calculated average costs in insurance plans with high and low levels of current coverage for limb prostheses.

The bill states that “[c]overage for the prosthetic devices shall be provided for the most appropriate medically necessary model that adequately meets the medical needs of the policyholder as determined by the treating physician.” If this language is interpreted to limit the ability of the plan to influence the choice of the device that meets the patient’s needs, it introduces some additional uncertainty into the analysis and is largely responsible for the relatively high value of the high-cost scenario.

Balancing these factors, Compass has estimated low, middle, and high cost scenarios. A summary of these estimates appears in Exhibit E1. The right-most column shows the mean annual premium change over the 5 years and the total dollar impact. It is important to note that the changes in premium costs in this summary are the weighted average across all plans. 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.

¹ In most cases, prostheses are covered under a durable medical equipment (DME) benefit that has a maximum of \$1500 per year. Since this benefit also covers other items in addition to prostheses, the coverage available for prostheses for a given individual in a given year may be less than \$1500 if he or she has used some of the DME benefit for other items.

Exhibit E1
Summary of Cost Impact Scenarios for Prosthesis Mandate

	2006	2007	2008	2009	2010	5-Year
Low Scenario						
Change in Annual Premium	\$ 0.32	\$ 0.33	\$ 0.34	\$ 0.35	\$ 0.36	\$ 0.34
Annual Dollar Impact (000s)	\$ 1,018	\$ 1,050	\$ 1,081	\$ 1,113	\$ 1,145	\$ 5,407
Mid-Range Scenario						
Change in Annual Premium	\$ 0.42	\$ 0.42	\$ 0.42	\$ 0.42	\$ 0.42	\$ 0.42
Annual Dollar Impact (000s)	\$ 1,332	\$ 1,334	\$ 1,336	\$ 1,338	\$ 1,340	\$ 6,680
High Scenario						
Change in Annual Premium	\$ 0.64	\$ 0.58	\$ 0.55	\$ 0.54	\$ 0.54	\$ 0.57
Annual Dollar Impact (000s)	\$ 2,049	\$ 1,848	\$ 1,773	\$ 1,738	\$ 1,748	\$ 9,157

Proposed Legal Requirement

Proposed House Bill 376 would require all health insurers, except Medicare, Medicaid, and other governmental programs, to provide coverage for prosthetic devices “that equals the coverage provided for such devices under the federal laws providing health insurance to the aged and disabled”. The relevant insured population consists of commercially fully-insured individuals less than 65 years of age, including those in both employer-sponsored plans and direct-purchase (i.e., non-group) policies.

Overview of Impact Calculation

The Division provided Compass with data gathered from major Massachusetts commercial insurers describing their experience with claims for prosthetic devices in their fully insured, under-65 population. This information came from two general groups of plans: those that already covered prosthetic devices at a level similar to the level required by the mandate, and those for which coverage was more limited. This second group of plans had a mix of coverages, starting with \$1500 per year under the durable medical equipment benefit, and also including more generous benefit plans.

The primary strategy of the analysis was to estimate the average cost of prosthetic benefits in the plans that already cover them fully (i.e., in the way described in the proposed mandate, HB 376) and subtract from this cost the estimated average cost of the plans that offer a less generous benefit. This difference in average cost is then multiplied by the number of people whose benefit would be improved by the proposed mandate. The major steps in the calculations follow, with more detailed discussion of key assumptions in the next section.

- 1) Estimate the Massachusetts insured population covered by the mandate. (See Appendix A.)
- 2) Using data provided by the Division, segment the insured population into a set of plans that generally fully covers prosthetic devices (consistent with the benefit described in HB 376) and a set of plans that have less generous benefits.
- 3) Using data provided by the Division, estimate the annual member use rate for each insured population segment and how the rate would change with the mandate in place. Apply the calculated rates to the insured population segments to derive the patients using the benefit with and without full coverage.
- 4) Using data provided by the Division, estimate the average cost per plan member per year and how the cost would change with the mandate.
- 5) Estimate the degree to which costs will be disproportionately heavier in the first year as people seek to access the richer benefit as soon as it becomes mandated.
- 6) Using data on insured population trends (Appendix A) and inflation assumptions calculate the trends in cost through 2010.
- 7) Calculate summary ratios required for this analysis: the average cost per treatment per year and the impact of the mandated benefit on the premium, administrative expenses, and indirect costs of the relevant insurers.

Finally, Compass used a range of possible values in the major parameters to arrive at low-, mid-, and high-cost scenarios. The assumptions that have the largest influence on the estimated mandate impact are discussed in detail below.

Discussion of Major Assumptions

Below we describe in more detail the major assumption made in the calculations.

Insured Population

Compass developed population projections for this analysis, estimating the commercially fully-insured individuals in Massachusetts under 65 years of age. Exhibit I displays the estimates. Appendix A contains a detailed description of the sources and calculations used for the population estimates.²

² According to the Division, it is not clear whether federal law pre-empts the legislature's authority to require the Group Insurance Commission, as a self-insured plan, to include this benefit. However, if the mandate applies, and assuming that the GIC-covered population already has (the choice of) close to full coverage for limb prostheses, we estimate that the cost of the mandate for that population could amount to up to \$80,000 over the course of 5 years. The cost increase might result from changes in who has discretion for selecting treatment.

Definition of Prosthesis

Compass' analysis is based on the Division's data, collected from major Massachusetts insurers, which assumes that prostheses do not include implants such as joint implants or breast implants, but only external limb prosthetic devices, such as artificial limbs, along with associated supporting equipment (e.g., special sleeves, batteries) and maintenance costs.

Current Limb Prostheses Costs for Insured Populations

As part of its efforts to gather data relevant to estimating the effect of this mandate, the Division surveyed the major insurers in Massachusetts to determine the extent to which they currently cover prosthetic devices. In summary, the plans break down into those that provide full coverage for limb prostheses (subject to copayments, deductibles, etc.) and those that limit coverage either under a durable medical equipment (DME) limit or a separate limit for such devices.

Using the data the Division provided on the large population for which the prosthesis benefit is unlimited, Compass estimated the average cost per person for these "fully-covered" persons. The remainder of the insured population has a variety of benefit plans with a mixture of caps and other limitations; Compass calculated a weighted average cost for those groups. Average annual costs per plan member for prosthetic devices are higher in plans that fully cover them than in plans that limit them, roughly \$1.81 per member per year compared to \$0.85.

The high coverage plans had 0.020% of members with a paid claim for a prosthetic device in a given year, while the lower coverage plans had 0.029% of members with a paid claim. The lower penetration rate in the well-covered plans was more than offset by a much larger payment per person per year (for those who did have a claim paid) of \$4,439 vs. \$1,458 per person per year in the plans with a more limited benefit. Of this cost, more than 97% was related to purchase of devices, with the remainder related to repairs.

Populations in plans that already fully cover prosthetic devices will generally be unaffected by the mandate (with exceptions covered below). In contrast, we would expect cost in plans that currently do not cover prosthetic devices to rise towards the levels that approximate the levels in plans that provide full coverage. Therefore, the impact of the mandate is largely captured by measuring the average cost difference between the fully covered and other groups, and multiplying this difference by the number of people in the other groups.

Previous Self-selection and Physician Discretion in Treatment

Because some plans fully cover prostheses and some subject them to limits, we can estimate the effect of the mandate, subject to some limitations.

First, to the extent that people in need of expensive limb prostheses have the option to choose coverage (e.g., with an employer offering a choice of plans or by switching jobs) it is possible they have already placed themselves disproportionately into the high-coverage group. That is, the plans with richer prosthesis benefits may have experienced adverse selection of individuals requiring prostheses. In that case we would expect the mandate to induce a somewhat less dramatic rise in costs per member in the plans currently offering limited coverage. To account for this we will assume that in the low cost scenario, the per-member cost increase is 10 percent lower than it would otherwise have been.

Second, the bill provides that coverage for the prosthetic devices “shall be provided for the most appropriate medically necessary model that adequately meets the medical needs of such employees as determined by the treating physician.” The Division has not stated whether this standard marks an important departure from the standard in current plans, in that the bill might be interpreted to provide that the physician rather than the plan determines the appropriate prosthetic device. While physicians and insurers would nominally be held to the same standard, it’s reasonable to expect that on average a physician would be likely to specify treatment that costs more.

The Division received information from the Managed Care Ombudsman that tends to support this possibility. The few requests for review of denied claims that the Ombudsman reported were for situations where the patient wanted a more expensive prosthesis than the plan allowed.

In estimating the high-cost scenario, Compass increased the average device cost by 10% to account for this effect. Furthermore this increase would likely affect the average device cost of even those plans that already fully cover limb prostheses.

Note that the effect of this potential cost increase and the effect of the potential adverse selection in the previous section drive the mandate impact in opposite directions. In the mid-range scenario they are approximately balanced.

First-year Demand

If the mandate passes, we can expect that some people who needed more expensive prostheses but previously could not afford them without full coverage, are likely to take advantage of the benefit. Furthermore, they may do so in the first year, creating a “bubble” of patients that will diminish over time.

The Division has no data on the number of patients with this pent-up demand. Compass accounted for them in the first-year estimate, bumping it up by 10 and 25 percent, in the mid- and high-cost scenarios, for plans that previously had limited coverage. Subsequent years are assumed to be less affected. (In Exhibits E1 and II, only in the high-cost scenario time trends does this boost noticeably counteract the effects of population growth and unit cost inflation.)

Medicare Standards for Copayments and Fees

The bill's language states that insurers must provide "coverage for prosthetic devices that equals the coverage provided for such devices under the federal laws providing health insurance to the aged and disabled". The bill allows insurers to offer coverage better than that specified in the bill. Compass has no information on whether the bill will be interpreted to require insurers to offer copayment terms and/or fee schedules that are no worse than Medicare's.

The largest source of claims data in plans in which prosthetic devices were fully covered came from plans that typically required a 20% copayment, approximately the Medicare standard. We therefore made no additional adjustment to try and match the Medicare copayment standard.

If anything, we expect Medicare reimbursement for a given prosthetic device to be lower than commercial reimbursement, so we will not assume the mandate will increase the cost of devices for plans that already cover them, other than the effect already discussed above related to device quality demanded.

Calculation of Premium Costs

Changes to premium levels were calculated by dividing the projected increases in claims costs by the projected enrollments in the insured populations.

In addition to the incremental medical care costs previously discussed, the overall impact of a mandate on the costs of health insurance in the Commonwealth includes two other components: Incremental administrative expenses and incremental margins. A detailed description of the calculation of these two components appears in Appendix B.

Incremental administrative expenses would be incurred for activities associated with the implementation of the mandate such as modifications to benefit plan materials, claims processing system changes, training/communication material for staff, etc.

Incremental margin is required for the insurer to maintain adequate reserve levels as required by the Massachusetts Division of Insurance. Required reserves are based on the claim levels for the insurer, and since the mandate would increase claim levels, it would

increase required reserve levels and therefore incrementally increase the total dollars of margin required to meet those reserve levels.

Impact on Individual Plans

The exhibits in this report, such as E1 and II, reflect the cost to Massachusetts insurance plans and their customers as a whole. 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. The dollar impact of the mandate will be spread across a smaller insured member base, resulting in larger premium increases than are reflected in the overall numbers in Exhibits E1 and II.

Results

The results of the analysis are displayed in Exhibit II. The impact in 2006 is estimated to range from \$1.0 million to \$2.0 million, with a mid-range estimate of \$1.3 million. 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.

The estimated impact for the full 5 years ranges from \$5.4 million to \$9.2 million, with a mid-range estimate of \$6.7 million. The average annual premium increase across the 5-year period would range from \$0.34 to \$0.57, with a mid-range estimate of \$0.42.

The key pieces of information that would allow the estimated ranges to be narrowed are more complete information, mostly from smaller plans, on the breakdown of current benefit levels, and better information on the possible effect of placing decisions about the choice of device solely in the hands of the physician.

Exhibits

Exhibit I
Insured Population Projections

	2006	2007	2008	2009	2010
Employer - FI	2,922,233	2,927,500	2,932,667	2,938,033	2,943,300
Direct (Individual)	279,100	275,500	276,100	276,700	277,200
Total	3,201,333	3,203,000	3,208,767	3,214,733	3,220,500

**Exhibit II
Summary of Cost Impact Scenarios for Prosthesis Mandate**

Low Scenario	2006	2007	2008	2009	2010	5-Year
Per Patient Impact*	\$ 1,490	\$ 1,535	\$ 1,580	\$ 1,625	\$ 1,669	\$ 1,580
Monthly Premium Impact - Claims	\$ 0.0253	\$ 0.0261	\$ 0.0269	\$ 0.0276	\$ 0.0284	\$ 0.0269
Administration Premium Impact	\$ 0.0011	\$ 0.0011	\$ 0.0012	\$ 0.0012	\$ 0.0012	\$ 0.0012
Total Monthly Premium Impact	\$ 0.0265	\$ 0.0272	\$ 0.0280	\$ 0.0288	\$ 0.0296	\$ 0.0280
Dollar Impact - Claims (000s)	\$ 975	\$ 1,006	\$ 1,036	\$ 1,067	\$ 1,097	\$ 5,182
Administration (000s)	\$ 42	\$ 44	\$ 45	\$ 46	\$ 48	\$ 225
Total Impact (000s)	\$ 1,018	\$ 1,050	\$ 1,081	\$ 1,113	\$ 1,145	\$ 5,407
Mid-Range Scenario	2006	2007	2008	2009	2010	5-Year
Per Patient Impact*	\$ 1,828	\$ 1,849	\$ 1,870	\$ 1,891	\$ 1,912	\$ 1,870
Monthly Premium Impact - Claims	\$ 0.0325	\$ 0.0325	\$ 0.0325	\$ 0.0325	\$ 0.0325	\$ 0.0325
Administration Premium Impact	\$ 0.0022	\$ 0.0022	\$ 0.0022	\$ 0.0022	\$ 0.0022	\$ 0.0022
Total Monthly Premium Impact	\$ 0.0346	\$ 0.0346	\$ 0.0347	\$ 0.0347	\$ 0.0347	\$ 0.0347
Dollar Impact - Claims (000s)	\$ 1,249	\$ 1,251	\$ 1,253	\$ 1,255	\$ 1,257	\$ 6,265
Administration (000s)	\$ 83	\$ 83	\$ 83	\$ 83	\$ 83	\$ 415
Total Impact (000s)	\$ 1,332	\$ 1,334	\$ 1,336	\$ 1,338	\$ 1,340	\$ 6,680
High Scenario	2006	2007	2008	2009	2010	5-Year
Per Patient Impact*	\$ 2,455	\$ 2,452	\$ 2,449	\$ 2,445	\$ 2,442	\$ 2,449
Monthly Premium Impact - Claims	\$ 0.0490	\$ 0.0440	\$ 0.0422	\$ 0.0413	\$ 0.0415	\$ 0.0436
Administration Premium Impact	\$ 0.0044	\$ 0.0039	\$ 0.0038	\$ 0.0037	\$ 0.0037	\$ 0.0039
Total Monthly Premium Impact	\$ 0.0534	\$ 0.0480	\$ 0.0459	\$ 0.0450	\$ 0.0452	\$ 0.0475
Dollar Impact - Claims (000s)	\$ 1,881	\$ 1,697	\$ 1,628	\$ 1,596	\$ 1,605	\$ 8,409
Administration (000s)	\$ 167	\$ 151	\$ 145	\$ 142	\$ 143	\$ 748
Total Impact (000s)	\$ 2,049	\$ 1,848	\$ 1,773	\$ 1,738	\$ 1,748	\$ 9,157

*Per patient refers to patients accessing the prosthesis benefit that year.

Appendices

Appendix A

Development of Population Estimates

Overview of Population Projection Model

Compass maintains a Massachusetts population projection model to support its efforts to analyze the cost impact of various mandates enacted by the Massachusetts legislature. This model projects the Massachusetts population at the following level of detail:

- By year through 2010
- By gender
- By age grouping
 - Less than 18
 - 18-64
 - 65 or greater
- By insurance status for under 65 population
 - Uninsured
 - Insured by employer-sponsored fully insured plan
 - Insured by employer-sponsored self-insured plan
 - Insured by direct-purchase policy
 - Insured by MassHealth
 - Insured by other Medicaid programs

For analysis of the limb prosthesis mandate, the following categories were required:

- Individuals under 65 years of age covered by employer-sponsored fully insured plans
- Individuals under 65 covered by direct-purchase plans.

Detailed Description of Population Projection Model

The population projections for this analysis were developed by reference to various reports, tables, and other data sources at the following web sites:

- Massachusetts Division of Health Care Finance and Policy (“MADHCFP”)
- United States Census Bureau (“Census Bureau”)
- Massachusetts Institute of Social and Economic Research (“MISER”)
- Kaiser Family Foundation
- Centers for Medicare and Medicaid Services (“CMS”)

The first step was to determine the actual Massachusetts population split by age group. According to the Massachusetts “Quickfacts” exhibit on the Census Bureau website, the Massachusetts population in 2003 was 6,433,000. The current population was allocated

by age by referring to percentages in the Quickfacts exhibit for “Persons Under 18 Years Old” and “Persons 65 Years Old and Over” for 2000. The current population was allocated by gender by referring to a report on the Census Bureau web site entitled: “Population Projections for States by Selected Age Groups and Sex: 1995-2020”. From this report, the female percentage, by age category, of the projected population could be determined.

To project future populations we used a population projection on the MISER website which projected the Massachusetts population by gender and quinquennial age category out to 2010 and 2020. The growth rates implicit in the MISER projections for 2010 reflected the slowing in growth seen in recent years and appeared to be a suitable basis for projecting to 2010.

The MISER projections for 2010 included age and gender detail, which we used to allocate the projected 2010 population. The allocation by age and gender for intermediate years was based on interpolation of the 2003 allocation derived from 2003 Census data and the 2010 MISER projections.

The final step was to determine the insurance status for the projected population. To do this, we referred to several sources:

- 1.) Historical Health Insurance Tables HI-5 and HI-6 on the Census Bureau web site show a split of the Massachusetts population by health insurance status. Table HI-5 is for Children under 18 and Table HI-6 is for People Under Age 65.
- 2.) From the MADHCFP web site, we referred to a report entitled “Health Insurance Status of Massachusetts Residents (Fourth Edition)” with a publication date of November 2004. Table 1 of this report indicates that 3.2% of Massachusetts residents ages 0-18 are uninsured, the same rate as in 2002. The same table indicates that 10.6% of the non-elderly adult population of Massachusetts was uninsured in 2004, an increase over 9.2% in 2002.
- 3.) Table A-2 of a report entitled “Health Insurance Coverage in the United States: 2002” on the Census Bureau web site shows information on the nature of health insurance coverage in 2002. This detail is available at the national and regional level, but not at the state level. From this report, an estimate of the portion of insured Massachusetts residents covered by individual or direct-purchased health insurance policies (whether purchased in the non-group market or, for sole proprietors, in the small group market) can be determined. This estimate was made by assuming that direct-purchase health insurance is less prevalent in Massachusetts than in the Northeast region. In general, in the New England states, individual health insurance is more heavily regulated, resulting in more costly policies owing to community rating requirements. As a result, enrollment in individual or direct-purchase policies tends to be lower. This presumption is consistent with estimates of direct purchased health insurance on both the Kaiser and Census Bureau web sites.

- 4.) Overall Medicaid enrollment statistics were taken from the Kaiser Family Foundation State Health Facts Online web site. MassHealth enrollment statistics were taken from a Section 1115 fact sheet found on the CMS web site.
- 5.) A MADHCFP report entitled “Source of Insurance Coverage for Massachusetts Residents (2002)” shows that 61% of the entire population of Massachusetts is covered by employer-sponsored plans.
- 6.) We relied on a MADHCFP study that determined that 27% of the insured population covered by employer-sponsored plans was covered by self-funded plans that were exempt from the requirements of these mandates.

The population and insurance status estimates from these various sources were not always consistent and judgment was required to resolve these discrepancies. With the data from these sources, we determined the insurance status as follows:

- 1.) We started with the distribution of the population by health insurance status for Massachusetts for 2002 as defined by the Historical Health Insurance Tables HI-5 and HI-6.
- 2.) Tables HI-5 and HI-6 appear to over-count the uninsured population and undercount the Medicaid population, based on the other statistics referred to above. Adjustments were made to correct for these discrepancies.
- 3.) The direct-purchase insured population reported in Historical Health Insurance Table HI-6 was adjusted upwards to better align with the estimates for the Northeast region according to the Census Bureau’s “Health Insurance Coverage in the United States: 2002”. This adjustment also enhances the consistency of the rest of the assumed distribution with the other data sources.
- 4.) Seventy three percent of the enrollment in employer-sponsored was assumed to be fully insured and the remaining 27% was assumed to be self-insured.
- 5.) Incremental shifts in the distribution were assumed based on past trends and expectations of future changes.

Appendix B

Development of Administrative Cost Estimates

The incremental administrative costs associated with a mandate consist of two components:

- 1.) Incremental Administrative Expenses
- 2.) Incremental Margins

Estimates of the impact of these adjustments were derived by reviewing financial statement data for the major health carriers operating in Massachusetts.

The low scenario includes 3% for incremental pre-tax margin and 1.2% for incremental administrative expenses, or a total of 4.2%. Our high scenario includes 6% for incremental pre-tax margin and 4.2% for incremental expenses, or a total of 10.2%.

Based on financial statement data, it appears that overall administrative expenses for the major Massachusetts health plans range from 8 to 12% of revenue. Different health carriers will have different administrative expense structures. It is conceivable that administrative expenses could be higher for a smaller insurer with less economies of scale. For this analysis, we assumed overall administrative expense ratios of 8% - 14% of revenue. Mandates affect only a small proportion of these administrative expenses.

For this analysis, we assumed that the proportion of administrative expenses that will be affected by mandates will range from 15% to 30%. So, for example, if administrative expenses are 10% and the proportion affected by a mandate is 20%, we assume that 2% of total expenses are affected.

Therefore, the low impact will be 1.2% (15% of 8%) and the high impact will be 4.2% (30% of 14%). In each case, this factor will only apply to the incremental medical claim expense estimated earlier in this report, which is itself a tiny percentage of the overall healthcare premium.

All health carriers are required by state insurance regulators to maintain adequate ratios of net worth to premium, as measured by the risk-based capital (RBC) formula. Therefore, health carriers must earn margins sufficient to maintain net worth at acceptable levels. The actual level depends on enrollment growth, trend levels and management discretion, among other factors.

In addition, it is assumed that all health carriers are subject to federal income taxation. Therefore, the residual margin after payment of federal taxes must be sufficient to maintain adequate net worth levels, as determined by the RBC formula.

In this analysis, it is assumed that the minimum pre-tax margin would be 3%. Because of RBC requirements, a health plan cannot set pre-tax margins any lower and reasonably

expect to maintain adequate net worth in today's trend environment. We further assumed that some carriers might choose to set margins of as much as 6%, so that net worth adequacy can be enhanced.

The analysis also assumes that the majority of health carriers in Massachusetts are non-profits and are not subject to state premium taxes. The impact of the mandate would be greater for a plan that pays premium taxes, as an appropriate provision would have to be made in the pricing.



March 8, 2005

Maria Schiff
Health Policy Manager
Massachusetts Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Maria:

The Massachusetts Association of Health Plans, on behalf of our member health plans, which provide health care coverage to approximately 2 million Massachusetts residents, appreciates the opportunity to offer our comments as part of the mandate review process concerning proposed House Bill 376. The legislation would mandate coverage for prosthetic devices that equals the coverage provided for such devices under Medicare and would eliminate health plan benefit programs that currently help to guide health plan member choices regarding prosthetic devices.

MAHP member health plans have indicated in responses to your survey on this mandate that they typically cover prosthetic devices that adequately allow health plan members to perform ordinary activities of daily living, up to the applicable benefit limit. Further, generally MAHP member health plans provide coverage for the repair of prosthetic devices.

We oppose House Bill 376 as presently drafted because of the impact it would have on the range of health plan products available to Massachusetts employers and consumers, and the potential increase in the cost of health care coverage that it will cause. Under House Bill 376, health plans would be required to cover the most appropriate medically necessary model that adequately meets the medical needs of such subscribers or members *as determined by the treating physician*. Health plans would not be able to apply their existing benefit limits. While less expensive prosthetic devices are available, some prostheses cost tens of thousands of dollars. As a result, eliminating the benefit limit on prosthetic devices could have a significant impact on premiums and would not necessarily result in a patient receiving the most appropriate prosthetic device.

In addition, MAHP is concerned that the language referring to the treating physician could be read to override applicable utilization management requirements, leaving health plans with no ability to review whether the prosthesis ordered by the member's physician is appropriate or whether an alternative prosthesis would better meet the member's medical needs. It should be noted that physicians are not usually directly involved in the selection of a prosthetic device for their patient, but rather generally expect that the vendor will help the member determine what type of prosthesis will best meet their needs and will assist with the fitting of the prosthesis.

Additionally, House Bill 376 would require that the member cost-sharing for prosthetic devices be the same as it is under Medicare. Because Medicare's deductible for prosthetic devices is only \$100, this requirement would effectively prohibit health plans in Massachusetts from offering a high-deductible health plan (HDHP) that utilizes a health savings account (HSA). This is because a federally qualified HDHP must have a deductible of no less than \$1000, adjusted annually for inflation. The State of Maine recently amended its prosthetics mandate to address this issue. Where HSAs have been available, the market has responded positively. According to a study released in January 2005 by America's Health Insurance Plans, last year 438,000 Americans picked HSAs, with 30 percent of people buying the new plans previously uninsured and nearly half the covered people over the age of 40. Therefore, House Bill 376 would have the effect of preventing employers and consumers in the state from accessing this coverage option.

By tying prosthetic coverage to be the same as Medicare, House Bill 376 would increase the cost of coverage by requiring health plans to reimburse at the same rate as Medicare. As the survey responses indicate, several health plans have contractual relations with specific prostheses makers, which enables the plans to negotiate discounts below what Medicare reimburses. Requiring the plans to pay at the same rate as Medicare removes their ability to control premium costs for employers and consumers. Ultimately, this will add to the cost of coverage.

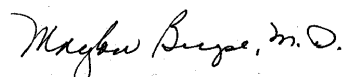
In general, MAHP opposes mandating health care benefits because it removes the flexibility employers and consumers need to manage their health care costs and can lead to significant increases in the cost of coverage. Massachusetts currently has 27 mandated health benefit laws, among the most of any state in the country. Nearly half of these mandates were enacted over the last five years, often with little or no analysis of their impact on premiums or clinical appropriateness. Fortunately, we now have this process whereby mandates can be properly reviewed before the Legislature acts.

In its January 2002 report, the Massachusetts Health Care Task Force found that mandates enacted by the Massachusetts Legislature have significantly contributed to the rising cost of health insurance. The Task Force report went on to state that "To avoid losing private sector coverage in the face of cost increases, flexibility in design is needed."

While any one mandate may not significantly increase the cost of coverage, the cumulative effect over time of adding mandate on top of mandate can and does affect cost. For example, the cost of the nine proposed mandates DHCFP has examined since the mandate review law passed would require between \$77.4 million and \$226.8 million in new health care spending if all were to become law.

Again, we appreciate the opportunity to offer our comments on this issue. Please let me know if you have any questions or if there is any other information we can provide.

Sincerely,



Marylou Buyse, M.D.
President



John J. Curley, Jr.
Vice President
Public, Government and Regulatory Affairs
Corporate Affairs Division

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Boston, MA 02215-3326

VIA EMAIL
AND FIRST CLASS MAIL

December 30, 2004

Maria Schiff, Health Policy Manager
Massachusetts Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Ms. Schiff:

Blue Cross and Blue Shield of Massachusetts, Inc. ("BCBSMA") writes in response to the Division of Health Care Finance and Policy's (the "Division") questionnaire received via electronic mail on December 2, 2004, concerning House Bill 376, *An Act Providing Health Care Coverage for Certain Prosthetic Devices* ("HB 376"). We appreciate the opportunity to provide our input as the Division conducts its analysis of the medical efficacy and financial impact of the proposed legislation pursuant to Section 3 of Chapter 300 of the Acts of 2002. Our response to the Division's questionnaire is enclosed.

As stated in the questionnaire, BCBSMA provides coverage for prosthetic devices for our members that equals and, in many cases, surpasses the coverage provided by Medicare. We cover devices used to replace the function of a missing body part or made to be fitted to the member's body as an external substitute. Under HB 376 the definition of a *prosthetic device* is limited to "*an artificial device to replace, in whole or in part, an arm or leg.*" In addition to devices to replace an arm or a leg, BCBSMA provides coverage for other types of prosthetic devices, such as eye and scalp prostheses.

Our prosthetic coverage does not fall under our durable medical (DME) equipment coverage which, as you may know, has an annual dollar limit of \$1,500. Under all of our group plans, there is no annual dollar limit on benefits for prosthetic devices. Our nongroup guaranteed-issue HMO and PPO plans include a \$1,500 annual maximum for prosthetic devices. However, a capped prostheses benefit is not specific to BCBSMA's nongroup plans. In accordance with the regulations that govern nongroup plans in Massachusetts, carriers offering such plans must provide *at least* a \$1,500 annual prostheses benefit. BCBSMA's coverage is consistent with the standardized benefit requirements prescribed in the regulations. Requiring nongroup plans to provide coverage for prosthetic devices that equals the coverage provided by Medicare, which

provides coverage for 80 percent of the cost of the device with no annual maximum, would result in a premium increase for nongroup members.

Under group and nongroup plans, coverage for prosthetic devices is provided for the least expensive prosthesis of its type that meets the needs of our members. As written, the bill requires coverage for *“the most appropriate medically necessary model that adequately meets the medical needs of the policyholder, as determined by the treating physician.”* We believe that this language clearly allows health plans to continue to cover the devices that are appropriate to the medical needs of the member. Health plans should not be required to cover the most expensive device in instances where a clinically effective and less expensive alternative may exist. Also, health plans should not be required to cover devices which are considered investigational or do not meet a health plan’s medical technology assessment criteria. Precluding insurers from managing the purchase of these devices could have a considerable financial impact.

At a time of uncertainty in the Massachusetts economy and in the face of the increasing financial stresses in our health care system, mandates have the potential to raise the cost of health care, may not be appropriate from a quality perspective and, therefore, should be subject to thoughtful deliberation. We appreciate the opportunity to provide feedback on this proposal and look forward to continuing to work with the Division as it conducts analysis of other proposed legislation pursuant to Section 3. If you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, reading "John J. Curley, Jr." in a cursive style.

John J. Curley, Jr.

Enclosure