A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature

Review and Evaluation of LD 1003
An Act to Improve Outcomes for Persons with Limb Loss

February 2022

Prepared by:
Donna Novak, FCA, ASA, MAAA
Al Bingham, FSA, MAAA
of NovaRest, Inc.
Marti Hooper, ASA, MAAA
of the Maine Bureau of Insurance

Contents

I. Executive Summary

The Joint Standing Committee on Health Coverage, Insurance and Financial Services (Committee) of the 130th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 1003, An Act to Improve Outcomes for Persons with Limb Loss. The review was conducted as required by 24-A M.R.S.A § 2752 to answer prescribed questions about the bill including the estimated cost. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau of Insurance, and are intended to respond to the Committee's request.

LD 1003 proposes an amendment to 24-A M.R.S.A § 4315. Coverage of Prosthetic Devices which requires the coverage for a prosthetic device that adequately meets the medical needs of an enrollee. Here, a "prosthetic device" means an artificial device to replace, in whole or part, an arm or a leg. Through LD 1003, a carrier shall provide coverage for prosthetic devices in all health plans, that at minimum, equals, the coverage and payment for prosthetic devices under federal laws and regulations for the aged and disabled. The amendment adds:

> "*For an enrollee under 18 years of age, in addition to the coverage of a prosthetic device required …, a prosthetic device determined by the enrollee's provider … to be the most appropriate model that adequately meets the recreational needs of the enrollee, as applicable, to maximize the enrollee's desire to ambulate, run, bike, and swim and to maximize upper limb function."*

Coverage under this section of the statute must also be provided for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider. Except as provided above, coverage is not required for a prosthetic device that is designed exclusively for athletic purposes.

This report includes information from several sources to provide more than one perspective on the proposed mandate with the intention of providing an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her own conclusions.

The Affordable Care Act (ACA) describes a broad set of benefits that must be included in any Essential Health Benefits (EHB) package. In its December 2011 bulletin, the Department of Health and Human Services (HHS) provided guidance on the types of health benefit plans each state could consider when determining a benchmark EHB plan for its residents. Each state had the opportunity to update its benchmark plan effective for 2017. Maine has chosen the small group Anthem Health Plans of Main (Anthem BCBS) PPO Off Exchange Blue Choice as its

2017-2022 benchmark plan. [1] Anthem BCBS does not cover benefits prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes. It is important to note that the ACA requires states to fund the cost of any mandates that are not included in the state specific EHBs for policies purchased through the Health Exchange Market.

Maine law currently mandates coverage for prosthetics for "medical needs".[2]

This amendment to the bill would require coverage of for "recreational" prosthetics. As this type of prosthetic is in addition to the currently covered prosthetic for "medical need", we believe it is a new benefit. Therefore, we believe this bill is a new benefit whose cost would be defrayed by the state, but this is not a legal interpretation, nor should it be considered legal advice.

NovaRest anticipates this bill amendment will result in increases in health insurance premiums between 0.00% - 0.02% or $0.01 - $0.12 PMPM. With an estimated 62,250 members in Maine enrolled in qualified health plans, we estimate the cost to the state of $9,000 to $89,000.

Please note our estimate above is based on the full cost of the benefit. The impact on premiums would likely be less than estimated due to patient cost sharing. While we cannot anticipate what cost sharing arrangement each carrier will apply, one carrier provided an estimate with a 20% coinsurance member cost sharing. Using a 20% coinsurance member cost sharing level reduces the estimated cost impact to carriers to $0.01 PMPM - $0.10 PMPM. With a 20% coinsurance member cost sharing level defined, the total cost to the state would be $7,000 to $72,000. We are unclear if the other carriers provided a cost estimate with or without cost sharing. this cost would be reflected in all member's premiums although only children would be eligible for benefits.

We have the following questions about the language of the bill:

1. It is not clear what type of prosthetic would meet a "recreational need" as stated in the bill but is not "designed exclusively for athletic purposes" as excluded from coverage in current statute. For example,
    a. Many upper body terminal devices are specific to certain tasks so the definition "maximizing upper limb function" may overlap with a prosthetic designed exclusively for athletic purposes.
    b. Similarly, according to the medical providers we interviewed, some amputees would not use a prosthetic to swim (either because it is easier to swim without one or because the salt or chlorine would damage the prosthetic), while others may need a waterproof paddle-type device. That type of device could be used for either recreational or athletic purposes.

[1] Centers for Medicare and Medicaid Services. "2017-2020 EHB Benchmark Plan Information." https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb html#North%20Dakota. Accessed September 13, 2021.
[2] Title 24-A, §4315: Coverage of Prosthetic Devices, https://legislature maine.gov/statutes/24-A/title24-Asec4315.html.

II. Background

Condition

There are different instances in which a person can experience limb loss.

- Traumatic amputation results from an injury;
- Surgical amputation occurs when a limb must be removed due to illness;
- Congenital amputation refers to a missing or incompletely formed hand, foot, arm, or leg that is present at birth.[3]
- Amputation is also sometimes called upper and lower limb reduction, although this is a broader term that can mean a limb that has not been fully developed as well as a limb that is missing.[4]

Currently, *medically necessary* prostheses for children are covered by insurance carriers. Doctors we interviewed, and supporters of the bill explained the need for a recreational prosthetic. They noted as an example, that the "SACH" foot, the simplest type of prosthetic foot, is not suitable for moderate to high activity not allowing a child to be very mobile. Putting extreme amounts of pressure on that type of prosthetic devices can damage or even break it. Jordan Simpson, an amputee, said that "with its fixed ankle, I felt like I was running on a brick" in her testimony.[5]

Incidence

There are about 2 million people living with limb loss in the United States, with approximately 185,000 amputations occurring each year.[6] A recent study found that the prevalence of major lower limb loss in children was an estimated 38.5 cases per 100,000 commercially insured children in the US. Congenital deficiencies accounted for 84% of cases, followed by 13.5% from trauma.[7] The CDC estimates that 1 in every 1,900 babies is born with a limb reduction defect in the US.[8]

---

[3] Shores, Jaimie Troyal. "Amputation." Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/amputation.

[4] "Facts about Upper and Lower Limb Reduction Defects." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 26 Oct. 2020, https://www.cdc.gov/ncbddd/birthdefects/ul-limbreductiondefects.html.

[5] "130th Maine Legislature, First Special Session." LD 1003, HP 741, Text and Status, 130th Legislature, First Special Session, https://legislature.maine.gov/legis/bills/display_ps.asp?LD=1003&snum=130.

[6] Administration, Web. "Limb Loss Statistics." Amputee Coalition, 1 Aug. 2017, https://www.amputee-coalition.org/resources/limb-loss-statistics/.

[7] McLarney, Mitra1; Pezzin, Liliana E2; McGinley, Emily L3; Prosser, Laura4; Dillingham, Timothy R1, The prevalence of lower limb loss in children and associated costs of prosthetic devices: A national study of commercial insurance claims, Prosthetics and Orthotics International: April 2021 - Volume 45 - Issue 2 - p 115-122 doi: 10.1177/0309364620968645

[8] "Facts about Upper and Lower Limb Reduction Defects." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 26 Oct. 2020, https://www.cdc.gov/ncbddd/birthdefects/ul-limbreductiondefects.html.

Sources vary on the prevalence of child limb loss. One source indicated 25,000 children in the US living with limb loss.[9] Adjusting that to the Maine population, which contains about 0.41% of the total US population,[10] gives an estimated 144 children in Maine with limb loss. We found another source which indicated up to 4,500 children per year in the United States,[11] which over an 18-year period and adjusted for the Maine population results in 332 children in Maine with limb loss.[12]

Treatment

There are many types of prosthetics to replace missing hands and feet. These can be "active" or "passive" depending on the needs and budget of the patient.[13] Passive protheses are for cosmetic purposes only. They have no active motion but can improve functionality by creating a surface to stabilize objects. Most often, passive prostheses are prescribed to an infant as a first prosthesis. Active prostheses include "body-powered" prostheses and "myoelectric" prostheses. Body-powered prostheses use cables and a harness to direct movement. The patient uses motion from other parts of their body to mechanically control the prosthetic limb. Myoelectric prostheses are battery powered and use electrical signals sent from the patient's muscle movements to operate the prosthesis.[14]

Typically, children are eligible for a prosthetic device when they can stand, which is usually at 9 – 12 months. A physician may recommend a prosthesis as soon as possible so the child becomes used to it as they develop their sense of self and physically develop from sitting to standing to running and beyond.[15]

However, the doctors we interviewed stated that recreational prostheses are not usually needed until a child is older, as early as 4 or 5 years old. . Nicole Bove, Certified Orthotist and Prosthetic Resident at Scottish Rite for Children stated that a child would benefit from a recreational lower limb prosthesis as soon as the child starts finding limitations in activities while wearing their everyday prosthesis. For upper extremities, providers at the Children's Hospital of Atlanta stated that the average age is also at 4 or 5 years. These upper extremity prosthetics are more activity specific, such as for T-ball or monkey bars.

---

[9] Amputee Coalition. Limb Loss in the U.S., Https://Acl.gov/Sites/Default/Files/Programs/2021-04/Llam-Infographic-2021.Pdf.
[10] U.S. Census Bureau Quickfacts: United States. https://www.census.gov/quickfacts/fact/table/US/PST045219.
[11] "Limb Loss: Adapting to the Challenges and Reaching Milestones." Nationwide Children's, 19 Apr. 2018, https://www.nationwidechildrens.org/family-resources-education/700childrens/2018/04/limb-loss-adapting-to-the-challenges-and-hitting-milestones.
[12] We assume all children would live to age 18.
[13] "What Are the Four Types of Prosthetics?" Touchstone Rehabilitation, Touchstone Rehabilitation, 24 May 2021, https://www.touchstonerehabilitation.com/blog/what-are-the-four-types-of-prosthetics.
[14] "Prostheses." Ann & Robert H. Lurie Children's Hospital of Chicago, https://www.luriechildrens.org/en/specialties-conditions/pediatric-orthotics/prosthetics/.
[15] "Pediatric Prosthetics – Prosthetics for Kids." MCOP Prosthetics, 22 Oct. 2019, https://mcopro.com/prosthetics/specialties/pediatric-prosthetics/.

Doctors recommend regular maintenance of the prosthetic device every 6 months. Parts of the prosthesis may need to be adjusted if a child's activity level has changed and if they have grown or gained weight. Children may have to get a new prosthesis frequently, sockets may need to be changed, and regular adjustments need to be made. [16] The medical professionals we interviewed said that children often need their prosthesis replaced every 1 – 1.5 years. Sometimes the whole prosthesis would need to be changed, but other times only certain parts would need to be replaced. For example, if a child has gone up in foot size, it is possible to keep the lower prosthetic device the same and just replace the foot. The same is true for an upper extremity prosthesis. In these cases, usually the terminal device (component that replaces the hand) can be switched out to be activity specific.

Note that currently Maine health plans cover prosthetics for medical needs, so socket replacement and new medical needs prosthetics would already be covered.

Cost

Using the MaineCare fee schedule, a prosthetic including the components can cost up to $30,000, and we expect the cost to the commercial market to be higher. There is significant variation in the cost of the prosthetic based on the components, functionality, and materials needed. Based on our interview with Nicole Bove, in order to meet the activity-specific needs of a child using an upper limb recreational prosthesis, the Prosthetist would need to determine the appropriate terminal device(s) for the desired activities. These attachments can be interchanged onto the original socket interface by the patient depending on their daily needs. Using the MaineCare fee schedule,[17] fee costs for each upper body terminal devices are under $3,000. Similarly, while there are many lower prosthetic choices, the blade prosthesis[18] would meet most children's recreational needs for a cost of around $3,000 using the MaineCare fee schedule. As noted above, the costs under commercial insurance are likely to be higher.

[16] Ibid.
[17] There is an L6880 electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s) which is $23,000, but we do not believe this would be used for a child recreational prosthetic.
[18] L5980 and L5981

III. Social Impact

A. Social Impact of Mandating the Benefit

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

The service would not be utilized by a significant portion of the population. The bill states that this service only applies to children, which would be a small proportion of the population.

Sources vary on the prevalence of child limb loss. One source indicated 25,000 children in the US living with limb loss.[19] Adjusting that to the Maine population, which contains about 0.41% of the total US population,[20] gives an estimated 144 children in Maine suffering from limb loss. We found another source which indicated up to 4,500 children per year in the United States,[21] which over an 18-year period and adjusted for the Maine population results in 332 children in Maine with limb loss.

2. The extent to which the service or treatment is available to the population.

Prosthetic devices appear to be widely available and there are quite a few orthotic and prosthetic clinics located throughout Maine. The following are some of the companies who offer these services in Maine:

- AtlanticProCare has locations in Portland and Auburn.[22]
- Cunningham Prosthetic Care is located in Saco. [23]
- Advanced Orthotic Prosthetic Services Inc with locations in Auburn, Brunswick, Kennebunk, S. Portland, and Rangeley.[24]
- Hanger Clinic with locations in Auburn, Augusta, Bangor, Portland, Rockport, and Waterville.[25]
- Central Maine Orthotics & Prosthetics has locations in Waterville, Bangor, Wilton, Auburn, and Dover-Foxcroft.[26]

---

[19] Limb Loss in the U.S. (n 9)
[20] US Census Bureau Quickfacts (n 10)
[21] Adapting to the Challenges and Reaching Milestones (n 11)
[22] "About AtlanticProCare." AtlanticProCare, https://www.atlanticprocare.com/about.
[23] "Limb Loss Solutions - Prosthetics." Cunningham Prosthetic Care, http://www.cunninghamprostheticcare.com/limbloss.
[24] "Advance Orthotic Prosthetic Services Inc. Home." Advance Orthotic Prosthetic Services Inc. , http://www.advanceoandp.com/.
[25] "Orthotic and Prosthetic Care in ME." Hanger Clinic, https://hangerclinic.com/clinics/ME/.
[26] "Central Maine Orthotics & Prosthetics." Central Maine Orthotics & Prosthetics Home, https://www.centralmaineorthoticsprosthetic.com/.

3. The extent to which insurance coverage for this treatment is already available.

Per §4315 Coverage of Prosthetic Devices, carriers are required to cover a prosthetic device that adequately meets the medical needs of an enrollee. However, this does not include recreational needs, as proposed by LD 1003.

Currently Aetna, Anthem, Cigna, Community Health Options, Harvard Pilgrim HealthCare, and United HealthCare all cover medically necessary prostheses in addition to repair and maintenance for these devices. They also cover replacement when deemed necessary.

Aetna and United Healthcare indicated prosthetics are already covered and the bill would not impact cost, however, they did not indicate if a separate recreational prosthetic is covered. All other carriers indicated that they do not cover a separate recreational prosthetic.

4. If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.

Without coverage, a family would likely have to pay out of pocket for a recreational prosthetic, which would allow a child to recreate with their peers. Providers at the Children's Hospital of Atlanta mentioned that because recreational prosthetics are not covered by insurance, there are grants available for children who wish to receive a more athletic prosthetic; but these grants are difficult to get because there are so many requirements.

5. If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.

Purchasing a prosthetic for recreational purposes is expensive and the prosthetic needs will vary from child to child. According to the Washington Post, prosthetic limbs can cost from $5,000 to over $50,000.[27] If a child only requires a new terminal device which attaches to their currently covered prosthetic, the costs may be closer to the lower end of the range. However, some children may require an entire new limb which is substantially more expensive. There are also many additional costs that come with a prosthetic device. Children are constantly growing, so regular maintenance and replacement are necessary. According to providers at the Children's

[27] Furby, Kate. "Children Who Need Prosthetics Can Quickly Outgrow Them and Insurers Are Reluctant to Pay for Running Legs. Nonprofits Are Helping out." The Washington Post, WP Company, 24 Feb. 2020, https://www.washingtonpost.com/health/children-who-need-prosthetics-can-quickly-outgrow-them-and-insurers-are-reluctant-to-pay-for-running-legs-nonprofits-are-helping-out/2020/02/21/f5e86f54-1606-11ea-9110-3b34ce1d92b1_story html.

Hospital of Atlanta, a child would need a new prosthesis every 14 – 18 months. Every 6 months a child's prosthesis should be checked and evaluated to ensure they fit properly.

6. The level of public demand and the level of demand from providers for this treatment or service.

We estimate approximately 120 children in Maine annually are living with major limb loss[28] and would have a need for a recreational prosthetic. We are unaware of the level of demand from providers.

7. The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.

We estimate approximately 32 children in Maine are covered by the private individual and group markets and are living with major limb loss. According to the public hearing testimony for LD 1003, there were two testimonies submitted in support of the bill. Testimony in support for the law written by Jordan Simpson and Jenna Powers, students at the University of New England, argue that engaging in physical activities with others is not a luxury, but a necessity for relationship building and development. Furthermore, they state that the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [29]

8. The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.

No information is available.

9. The likelihood of meeting a consumer need as evidenced by the experience in other states.

No other states have passed similar legislation for recreational prosthetics.

10. The 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 available.

[28] Does not include finger or toe amputations

[29] "130th Maine Legislature, First Special Session." LD 1003, HP 741, Text and Status, 130th Legislature, First Special Session, http://legislature.maine.gov/legis/bills/display_ps.asp?LD=1003&snum=130.

11. The alternatives to meeting the identified need.

The following are the relevant portions of responses from commercial insurance carriers to the Bureau's request for information. We are not opining on the validity of the following assumptions or conclusions, but rather are repeating them as provided. Only carriers who were able to provide a discussion of alternatives are included.

Community Health Options: Community Health Options believes consideration should be made for the following:

- Determination of the most appropriate model should be based on evidence-based clinical guidelines and manufacturer guidelines.
- The cost of the prosthetic device should be the least expensive that meets the member's needs.
- If the most appropriate prosthetic device varies by recreational activity, the member should be limited to the one device prior to age 18 which meets the needs of the member's highest priority.
- Medical certification should include physical therapy functional assessment and affirmation that the proposed device is the most suitable and least expensive to achieve the desired recreational activity.

12. Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.

The benefit could meet a broader social need. Current coverage provides for a medically necessary prosthetic device. The proposed benefit would also provide coverage for an additional recreational prosthesis. A recreational prosthetic could contribute to a child's social need to play and interact with their peers. Without these prosthetics, a child may have limited ability to participate in certain activities, potentially causing them to lose out on social and relationship building experiences with their peers.

13. The impact of any social stigma attached to the benefit upon the market.

There is unlikely to be any social stigma attached to using a recreational prosthetic. In fact, it would presumably be the opposite. As mentioned, lack of coverage of a recreational prosthetic prohibits children from participating in activities with their peers.

14. The impact of this benefit upon the other benefits currently offered.

Aetna: "Aetna allows medically necessary prosthetic devices consistent with the terms of the member's benefit plan. We will comply with this state mandate where applicable. We do not anticipate any impact to costs as this benefit is covered."

Anthem: "Anthem does not provide benefits for prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes. Benefits include the purchase, fitting, adjustments, repairs, and replacements."

Cigna: "We would not currently fund a separate prosthesis for recreation."

Community Health Options: "Community Health Options does not provide coverage for replacement prosthesis unless the member's medical needs are not being met by the current prosthetic or it is broken and cannot be repaired. Coverage does not extend to prosthetic devices designed exclusively for athletic or cosmetic purposes or provide enhanced performance beyond functional activities of daily living."

Harvard Pilgrim HealthCare: "The least costly prosthetic device (excluding prosthetic arms and legs) adequately to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. One item of each type of prosthetic device that meets a Member's medical need. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include prosthetic arms and legs which are the most appropriate model that meets the Member's medical needs (including myoelectric and bionic arms and legs that adequately allow you to perform Activities of Daily Living.)"

United HealthCare: "Since prosthetics are already currently covered, this mandate has no additional costs."

15. The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.

As premiums increase due to mandated benefits, some employers choose to self-insure in order to have more control over the benefits that they provide to employees and control the cost of health insurance premiums. Since this mandate will have a minimal impact on premiums it is unlikely this will cause any shifting to self-insurance.

16. The impact of making the benefit applicable to the state employee health insurance program.

Anthem stated that there was insufficient claims experience to allow them to develop the cost estimate for the State Employee Health Plan.

IV. Financial Impact

B. Financial Impact of Mandating Benefits

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

Medically necessary prosthetics are already covered and being provided by clinics around Maine. Since this benefit would be used by a small portion of the population, utilization and cost are not expected to increase materially.

None of the carriers were able to identify any potential lowering of costs. Given that the population of children amputees is small and the amendment restricts coverage to one prosthetic, this amount would not be significant.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

The proposed coverage would increase the number of recreational prosthetics provided to children amputees. However, given that the population of children amputees is small and the amendment restricts coverage to one prosthetic, this amount would not be significant.

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

Providing recreational prosthetics may lower costs in the long run with someone with limb loss and in other areas of health insurance. The Amputee Coalition states that for every dollar spent on rehabilitation, there is a savings of more than $11 in disability benefits. In addition, knee or hip problems resulting from lack of appropriate prosthetic care can result in health care costs

ranging from $80,000 to $150,000 over a lifetime.[30] Putting more strain on a daily prosthetic may result in damage to the prosthetic device, resulting in more expense for insurance providers. In addition, this treatment may lower the costs of mental health related issues and treatment. Children who are unable to participate in social or leisure activities with their peers due to a lack of appropriate prosthetics might see a negative impact on their quality of life and may develop mental health issues as a result.

4. The methods which will be instituted to manage the utilization and costs of the proposed mandate.

There is no language in the bill that prohibits medical management.

Cost sharing and benefit maximums are not mentioned in the bill, but the EHB benchmark plan allows for cost sharing for prosthetics. Therefore, we assume that cost sharing will be allowed.

5. The extent to which insurance coverage may affect the number and types of providers over the next five years.

As stated above in Section III, there are several orthotist and prosthetic clinics in Maine who offer the services that would be provided under this benefit. Since we do not anticipate a significant increase in utilization, we don't expect the number of providers to change significantly.

6. The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.

[30] "Introduce the Insurance Fairness for Amputees Act." Amputee Coalition, 2019. https://www.amputee-coalition.org/wp-content/uploads/2019/04/insurance-fairness-amputees-act-2019.pdf?utm_source=Amputee+Coalition+Master_Created+2019&utm_campaign=515f2033b6-HILL_DAY_2019_ATTENDEE_NOTIFICATION_02&utm_medium=email&utm_term=0_1ba571d004-515f2033b6-69387229#:~:text=For%20every%20dollar%20spent%20on,than%20%2411%20in%20disability%20benefits.&text=A%20study%20of%20Virginia's%20law,may%20reduce%20total%20overall%20costs.%E2%80%9D

Carrier Estimates

Aetna: "We do not anticipate any impact to costs as this benefit is covered."

Anthem: "We have insufficient claims experience to allow us to develop a cost estimate."

Cigna: "Assuming a low number of those covered having prosthetics, we would anticipate a small but not significant impact."

Community Health Options: "Without more specific information about specific coverage requirements related to benefit coverage for 'recreational' prostheses in Members less than 18, Health Options cannot provide an accurate estimate of overall cost implications. Further, cost estimates would be dependent upon interval frequency, whether there are limitations to the number of recreational activities per child, replacement terms as any child grows and develops, or implications of repair or replacement of dispensed devices once child is 18 or older. Based on prior experience, the submitted cost for a microprocessor-controlled prosthetic arm or leg can exceed $170,000. Since there are numerous codes submitted with advanced technology, there is significant administrative time to review the medical necessity of all services associated with the submitted request."

Harvard Pilgrim HealthCare: "The estimate of the mandate to meet this statutory requirement is unknown."

United HealthCare: "Since prosthetics are already currently covered, this mandate has no additional costs."

NovaRest Estimate

NovaRest estimates a net cost of $0.00 to $0.012 PMPM, or 0.00% to 0.02% of premium. With an estimated 62,250 members in Maine enrolled in individual qualified health plans, we estimate the cost to the state of $9,000 to $89,000. Please note this is the full cost of the benefit, and the carrier impact would likely be less due to cost sharing. While we cannot anticipate what cost sharing each carrier will apply. Using an estimate with 20% coinsurance member cost sharing, reduces the cost impact to carriers to $0.01 PMPM - $0.10 PMPM. The cost estimate was developed using the following sources:

- As discussed above, we estimate 144 to 332 children in Maine with limb loss.
- The amendment requires coverage in the fully-insured individual, small group, and large group market which cover approximately 27% of the total population under age 65.[31]
- Approximately 28% to 35% of amputees are upper body[32,33], we used 35%.
- Assume 8% of upper body limb loss are "major" cases, i.e. are not finger related.[34]
- 50% of lower body cases are not toe related.[35]
- Age distribution given by 2020 Vintage Population estimate.[36]
- Assume children under 5 would not need a recreational prosthetic
- Assume annual replacement of prosthetic
- Assume MaineCare costs are 40% of commercial costs.[37]
- Regarding lower body prosthetic:
    - Assume 50% of lower body recreational prosthetics would be the blade prosthetic L5980 or L5981, with a cost between $2,400 and $3,400 per MaineCare L-codes and fee-schedule.
    - Assume remaining 50% lower body prosthetic would not require a new socket, but would require a prosthetic with knee/hip/ankle/foot additions, with a total prosthetic cost between $2,300 to $16,700 per MaineCare L-codes and fee-schedule.
- Regarding upper body prosthetic:
    - Assume 75% of upper body recreational prosthetics would be terminal devices, with a cost between $290 and $3,100 per MaineCare L-codes and fee-schedule.
    - Assume remainder of upper body recreational prosthetic would not require a new socket, but would require a prosthetic with addition and terminal device, with a cost between $1,800 to $9,800 per MaineCare L-codes and fee-schedule.
- Claims, premium, risk adjustment, and membership information for 2020 from the National Association of Insurance Commissioners Supplemental Health Care Exhibit.

---

[31] 2020 SHCE. Health business and Life and Health business.

[32] Limb Loss in the U.S. (n 9)

[33] Yigiter K, Ulger O, Sener G, Akdogan S, Erbahçeci F, Bayar K. Demography and function of children with limb loss. Prosthet Orthot Int. 2005 Aug;29(2):131-8. doi: 10.1080/03093640500199703. PMID: 16281722.

[34] Ziegler-Graham, Kathryn, et al. "Estimating the Prevalence of Limb Loss in the United States: 2005 to 2050." Archives of Physical Medicine and Rehabilitation, vol. 89, no. 3, 1 Mar. 2008, pp. 422–429., https://doi.org/10.1016/j.apmr.2007.11.005.

[35] Ibid.

[36] Bureau, US Census. "State Population by Characteristics: 2010-2020." Census.gov, 8 Oct. 2021, https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-state-detail.html.

[37] Myers and Stauffer, LC. "Department of Health and Human Services - Maine.gov." MaineCare Comprehensive Rate System Evaluation Interim Report, 20 Jan. 2021, https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/MaineCare-Comprehensive-Rate-System-Evaluation-Interim-Report-2021.01.20.pdf.

7. The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.

There should not be any additional cost effect beyond benefit and administrative costs.

8. The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.

One potential savings of a recreational prosthetic is that since they are more durable and made for high activity, there will be less breakage and therefore minimized costs for repair and maintenance. Gabrielle Sinotte, MSPO, CPO, a certified prosthetist/orthotist, mentioned that it is common for less expensive pediatric prosthetic components to break prematurely because they cannot withstand the stresses from the higher activity level of a child.

Also, as mentioned above in #3, there are potential mental health cost savings. However, the population is so small we do not expect significant savings impact.

9. The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.

We expect a small, 0.00% - $0.02% increase to premiums.

10. The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.

We do not believe there will be cost shifting as the eligible population is very small.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit

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

Studies show that recreational prosthetics greatly improved children's lives and allowed them to pursue the activities they wanted.[38]

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

The bill will not apply to an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

Advocates indicated that patients who do not receive recreational prosthetics are unable to participate in certain social, leisure, athletic and school activities with their peers, which can lead to a poorer quality of life.

2. The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.

It is likely that only those who would benefit from the services would purchase the optional coverage. This would result in an alternative coverage that would be very expensive. This cost

[38] Walker JL, Coburn TR, Cottle W, Burke C, Talwalkar VR. Recreational terminal devices for children with upper extremity amputations. J Pediatr Orthop. 2008 Mar;28(2):271-3. doi: 10.1097/BPO.0b013e318164ee5b. PMID: 18388728.

would be reduced if the option were only available when the coverage was initially purchased, but it would then be less effective because many individuals would not anticipate needing the coverage and therefore would not purchase it.

3. The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.

We estimate an increase in cost of $0.01 - $0.08 PMPM for the amendment to LD 1003, or about 0.00% - 0.02% of premiums.

The estimated cost of current Maine mandates is detailed in Appendix A. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the number of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates is impacted by the fact that:

1. Some services would be provided and reimbursed in the absence of a mandate.
2. Certain services or providers will reduce claims in other areas.
3. Some mandates are required by Federal law.

The addition of 0.02% of premiums for the amendment to LD 1003 to the estimated cost of current Maine mandates, would result in a cumulative cost as shown below:

Total cost for groups larger than 20:	**12.61%**
Total cost for groups of 20 or fewer:	**12.66%**
Total cost for individual contracts:	**10.92%**

VII. Actuarial Memoranda

Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate of the proposed bill. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis by be incorrect. Appropriate staff is available to explain and/or clarify any

matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by carrier, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the bill's consideration. The reliance of parties other than the Maine Bureau of Insurance and the Joint Standing Committee on Health Coverage, Insurance and Financial Services on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by carriers included in the data call. We also made assumptions based on information gained from interviews with medical professionals. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable in their field.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice. We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

VIII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance
Cumulative Impact of Mandates in Maine

Report for the Year 2020

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

- ***Mental Health*** (Enacted 1983)

Mental health parity for group plans in Maine became effective July 1, 1996 and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims. Claims jumped sharply in 2020 by 1.3% to 5.2% for groups after steadily declining by a half point per year for the previous 3 years.

Maine mental health parity was only a mandated offer for individual plans until it was included in the essential health benefits for ACA (Affordable Care Act) individual and small group plans beginning 2014. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans. As expected, mental health claims have stabilized back to a lower level of 2.5% in 2017 after meeting pent-up demand of 9.4% in 2015. From 2018 to 2020 claims have increased slightly to an average of 3.5%, but still within a stabilized range.

- ***Substance Abuse*** (Enacted 1983)

Maine's mandate only applied to group coverage. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. Substance abuse claims paid have remained flat at 1.2% average for the past 3 years of the total group health claims. Individual substance abuse health claims have also remained flat at 1.0% for the past 3 years. As expected, substance abuse claims have leveled out as pent-up demand is met and carriers manage utilization.

- ***Chiropractic*** (Enacted 1986)

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2020, was 0.80% of total health claims. Prior to 2014, the level has typically been lower for individual than for group. Individual claims at 0.4% in 2020 have continued a trend of lower than group claims since 2017 when they were equivalent.

- ***Screening Mammography*** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography. We estimate the current 2020 levels of 0.9% for group and 1.0% for individual going forward. Coverage is required by ACA for preventive services.

- ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at $0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995)

This mandate requires coverage for metabolic formula and prescribed modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost increase or an insignificant cost increase because they already provide this coverage. Based on our report we estimate 0.2%.

- ***Minimum Maternity Stay*** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%. Coverage is required by ACA for preventive services.

- ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Group claims in 2020 were 2.0% compared to individual claims at 1.4% with the combined impact remaining level with past years at 1.7%.

- ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings. Our report estimated additional claims cost would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or approximately 0.07% of total premiums. Coverage is required by ACA for preventive services.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ***Hearing Aids*** (Enacted 2007 and revised 2019)

The prior mandate required coverage for a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium. For 1/2020 the hearing aid mandate is expanded to require adult hearing aids. Based on rate filings and a proposed mandate study we estimate 0.2% addition impact to rates to provide hearing aids to adults.

- ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium. Coverage is required by ACA for preventive services.

- ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ***Autism Spectrum* Disorders** (Enacted 2010)

This mandate was effective January 2011 and required all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. It was expanded to age 10 for January 2014 effective dates. A recent report estimated a cost of 0.3% of premium once the mandate is fully implemented if it included those under age 10. Based on that estimate and recently reported experience we are estimating this going forward.

- ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. This mandate was effective January 2011, and our report estimated a cost of 0.05% of premium.

- ***Chemotherapy Oral Medications*** (Enacted 2014)

Policies that provide chemotherapy treatment must provide coverage for prescribed orally administered anticancer medications equivalent to the coverage for IV or injected anticancer medication. No material increase in premium is expected.

- ***Bone Marrow Donor Testing*** (Enacted 2014)

Reimbursement for human leukocyte antigen testing to register as a bone marrow donor. Limited to $150 per lifetime. May not be applied to any deductible or other cost share. No material increase in premium is expected.

- ***Dental Hygienist*** (Enacted 2014)

Coverage for services provided by a dental hygiene therapist for policies with dental coverage. No material increase in premium is expected.

- ***Abuse-Deterrent Opioid Analgesic Drugs*** (Enacted 2015)

Coverage for abuse-deterrent opioid analgesic drugs on a basis not less favorable than that for opioid analgesic drugs that are not abuse-deterrent and are covered by the health plan. No material increase in premium is expected.

- ***Preventive Health Services*** (Enacted 2018)

Coverage for preventive health services including evidence-based items or services with a rating of A or B in the United States Preventive Services Task Force or equivalent, preventive care and screenings and immunizations supported by the federal DHHS. Currently covered and no material increase in premium is expected.

- ***Naturopathic Doctor*** (Enacted 2018)

Coverage for services provided by a naturopathic doctor when those services are covered when provided by any other health care provided and within the lawful scope of practice of the naturopathic doctor. No material increase in costs is expected and if the services are a substitute for medical doctor services, there may be a decrease in cost for some patients.

- ***Abortion Coverage*** (Enacted 2019)

This mandate requires that health insurance carriers who provide coverage for maternity services also provide coverage for abortion services except for employers granted a religious exclusion.

- ***Coverage for certified registered nurse anesthetists (CRNA)*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage for the services of certified registered nurse anesthetists provided to individuals.

- ***Coverage for certified midwives.*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage under those contracts for services performed by a certified nurse midwife to a patient who is referred to the certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse midwife.

- ***Coverage for HIV prevention drugs.*** (Enacted Federal 2021)

This mandate requires health insurance carriers to provide coverage for an enrollee for HIV prevention drugs that have been determined to be medically necessary by a health care provider.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups	1.24%
		Individual	1.13%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	5.15%
		Individual	3.58%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	Group	0.83%
		Individual	0.61%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.85%
		Individual	0.96%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the **maternity (length of stay)** and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	0.10%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	2.57%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	0.16%
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**	All Contracts	0
2009	Coverage for **independent dental hygienist**	All Contracts	0
2010	Coverage for **autism spectrum**	All Contracts	0.3%
2010	Coverage for **children's early intervention services**	All Contracts	0.05%
2014	Coverage for **chemotherapy oral medications**	All Contracts	0
2014	Coverage for **human leukocyte antigen testing**	All Contracts	0
2014	Coverage for **dental hygienist**	All Contracts	0
2015	Coverage for **abuse-deterrent opioid analgesic medications**	All Contracts	0
2018	Coverage for **naturopath**	All Contracts	0
2018	Coverage for **preventive services**	All Contracts	0
2019	Coverage for **adult hearing aids**	All Contracts	0.20%
2019	Coverage for **abortion services**	Individual	0.14%
		Group	0.19%
2021	Coverage for **certified registered nurse anesthetists**	All Contracts	0
2021	Coverage for **certified midwives**	All Contracts	0
2021	Coverage for **HIV prevention drugs**	All Contracts	0
	Total cost for groups larger than 20:		**12.59%**
	Total cost for groups of 20 or fewer:		**12.64%**
	Total cost for individual contracts:		**10.90%**

Appendix B: Other State Laws

Below is the list of states who have enacted laws for coverage for medically necessary prosthetics:

Connecticut § 38a-518t and § 38a-492t:

- (a) As used in this section, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or a leg, including a device that contains a microprocessor if such microprocessor-equipped device is determined by the insured's or enrollee's health care provider to be medically necessary. "Prosthetic device" does not include a device that is designed exclusively for athletic purposes.
    - (b) (1) Each group (and individual) health insurance policy providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for prosthetic devices that is at least equivalent to that provided under Medicare. Such coverage may be limited to a prosthetic device that is determined by the insured's or enrollee's health care provider to be the most appropriate to meet the medical needs of the insured or enrollee. Such prosthetic device shall not be considered durable medical equipment under such policy.
    - (2) Such policy shall provide coverage for the medically necessary repair or replacement of a prosthetic device, as determined by the insured's or enrollee's health care provider, unless such repair or replacement is necessitated by misuse or loss.
    - (3) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on substantially all other benefits provided under such policy, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, shall not be subject to the deductible limits set forth in this subdivision or under Medicare pursuant to subdivision (1) of this subsection.
- (c) A group health insurance policy may require prior authorization for prosthetic devices, provided such authorization is required in the same manner and to the same extent as is required for other covered benefits under such policy.

Iowa § 514C.25:

- 1. a. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for medically necessary prosthetic devices when prescribed by a physician licensed under chapter 148. Such coverage benefits for medically necessary prosthetic devices shall provide coverage for medically necessary prosthetic devices that, at a minimum, equals the coverage and payment for medically necessary prosthetic devices provided under the most recent federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. § 1395k, 1395l, and 1395m, and 42 C.F.R. §410.100, 414.202, 414.210, and 414.228, as applicable.
- b. For the purposes of this section, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

Virginia § 38.2-3418.15:

- A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall offer and make available coverage for medically necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:
    - 1. As used in this section: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb.
    - 2. Prosthetic device coverage does not include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.
    - 3. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.
    - 4. An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.
    - 5. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or services when such device or service is provided by an in-network provider.
    - 6. An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit.

Florida § 409.815:

(2) Benchmark benefits.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

- (h) *Durable medical equipment*. --Covered services include equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary, with the following limitations:
    - 4. Covered prosthetic devices include artificial eyes and limbs, braces, and other artificial aids.

Below are state laws who do not specify whether a prosthetic must be medically necessary.

Arizona § 36-2907:

A. Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:

- 5. Medical supplies, durable medical equipment, insulin pumps and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

B. The limitations and exclusions for health and medical services provided under this section are as follows:

- (b) Prosthetic devices do not include hearing aids, dentures, bone-anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to $12,500 per contract year.

Colorado: § 10-16-104:

With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

- Bulletin B-4.97: It is the Division's position that carriers issuing health benefit plans must provide coverage for the required prosthetic devices at 80% of the carrier allowable rates, minus an amount equivalent to the Medicare Part B deductible as of January 1 of each plan year in which the health benefit plan is issued or renewed. Carriers that offer a Catastrophic Plan, as the term is used in § 10-16-116 C.R.S., and plans that are eligible for a Health Savings Account (HSA), shall apply the medical deductible to prosthetic services, as required under federal law. A health benefit plan may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other covered benefit. Covered benefits are limited to the most appropriate model that meets the medical needs of the covered person as determined by the insured's treating physician. Repair and replacement of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

Utah § 31A-22-638:

- (1) For purposes of this section:
  - (a) “Orthotic device” means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.
    - (b)(i) “Prosthetic device” means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

        - (ii) "Prosthetic device" does not include an orthotic device.
    - (2)(a) Beginning January 1, 2011, an insurer, other than an insurer described in Subsection (2)(b), that provides a health benefit plan shall offer at least one plan, in each market where the insurer offers a health benefit plan, that provides coverage for benefits for prosthetics that includes:
        - (i) a prosthetic device;
        - (ii) all services and supplies necessary for the effective use of a prosthetic device, including:
            - (A) formulating its design;
            - (B) fabrication;
            - (C) material and component selection;
            - (D) measurements and fittings;
            - (E) static and dynamic alignments; and
            - (F) instructing the patient in the use of the prosthetic device;
        - (iii) all materials and components necessary to use the prosthetic device; and
        - (iv) any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.
    - (b) Beginning January 1, 2011, an insurer that is subject to Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall offer to a covered employer at least one plan that:
        - (i) provides coverage for prosthetics that complies with Subsections (2)(a)(i) through (iv); and
        - (ii) requires an employee who elects to purchase the coverage described in Subsection (2)(b)(i) to pay an increased premium to pay the costs of obtaining that coverage.
    - (c) At least one of the plans with the prosthetic benefits described in Subsections (2)(a) and (b) that is offered by an insurer described in this Subsection (2) shall have a coinsurance rate, that applies to physical injury generally and to prosthetics, of 80% to be paid by the insurer and 20% to be paid by the insured, if the prosthetic benefit is obtained from a person that the insurer contracts with or approves.
    - (d) For policies issued on or after July 1, 2010 until July 1, 2015, an insurer is exempt from the 30% index rating restrictions in Section 31A-30-106.1, and for the first year only that coverage under this section is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds the coverage under this section.
- (3) The coverage described in this section:
    - (a) shall, except as otherwise provided in this section, be made subject to cost-sharing provisions, including dollar limits, deductibles, copayments, and co-insurance, that are not less favorable to the insured than the cost-sharing provisions of the health benefit plan that apply to physical illness generally; and
    - (b) may limit coverage for the purchase, repair, or replacement of a

microprocessor component for a prosthetic device to $30,000, per limb, every three years.

- (4) If the coverage described in this section is provided through a managed care plan, offered under Chapter 45, Managed Care Organizations, the insured shall have access to medically necessary prosthetic clinical care, and to prosthetic devices and technology, from one or more prosthetic providers in the managed care plan's provider network.

California § 10123.7:

- (a) On or after January 1, 1986, an insurer issuing group health insurance shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group policyholder and the insurer. An insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom the insurer is negotiating. Coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Coverage for orthotic devices shall provide for coverage if the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. An insurer shall have the right to conduct a utilization review to determine medical necessity before authorizing these services.
- (b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to all benefits in the policy. A copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts contained in the policy.
- (c) This section shall not apply to Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

Appendix C: Letter from the Committee on Health Coverage, Insurance and Financial Services with Proposed Legislation

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 30, 2021

Eric A. Cioppa
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Health Coverage, Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 1003, An Act To Improve Outcomes for Persons with Limb Loss.**

During the committee's consideration of LD 1003, the committee developed a proposed amendment to the bill that requires an insurer to provide coverage to enrollees under 18 years of age for one prosthetic device designed to meet an enrollee's recreational needs. We ask that you review and evaluate this proposed amendment using the guidelines set out in Title 24-A § 2752. A copy of the proposed amendment is attached. In addition, we ask that the Bureau provide an analysis of the extent to which the bill expands coverage beyond the State's essential benefits package and, if so, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

Please submit the report to the committee no later than January 1, 2022 so the committee can take final action on LD 1003 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Heather B. Sanborn
Senate Chair

Rep. Denise A. Tepler
House Chair

Enclosure: Proposed Committee Amendment to LD 1003

cc: Marti Hooper, Bureau of Insurance
Rep. Colleen Madigan

Appendix D: LD 1003 Amendment

LD 1003
For HCIFS Committee Consideration at 5/11 Work Session
Based on Committee Discussion

Proposed Committee Amendment to LD 1003, An Act To Improve Outcomes for Persons with Limb Loss

Amend the bill by striking out everything after the enacting clause and before the title and inserting in its place the following:

§4315. Coverage of prosthetic devices

1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg.

2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for~~: a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee.~~

A. A prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee; and

B. For an enrollee under 18 years of age, in addition to coverage of a prosthetic device required by paragraph A, a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the recreational needs of the enrollee, as applicable, to maximize the enrollee's desire to ambulate, run, bike and swim and to maximize upper limb function.

3. Prior authorization. A carrier may require prior authorization for prosthetic devices in the same manner as prior authorization is required for any other covered benefit.

4. Repair or replacement. Coverage under this section must also be provided for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider.

5. Coverage under managed care plan. If coverage under this section is provided through a managed care plan, a carrier may require that prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device be provided by a vendor designated by the carrier.

6. Exclusions. ***Except as provided in subsection 2, paragraph B for an enrollee under 18 years of age, coverage*** ~~**Coverage**~~ is not required pursuant to this section for a prosthetic device that is designed exclusively for athletic purposes.

7. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.

LD 1003
For HCIFS Committee Consideration at 5/11 Work Session
Based on Committee Discussion

Summary

This amendment replaces the bill. The amendment requires an insurer to provide coverage to enrollees under 18 years of age for one prosthetic device designed to meet an enrollee's recreational needs. Under current law, insurers are required to provide coverage for a prosthetic device designed to meet an enrollee's medical needs.