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Inclusion of Prosthetic and Orthotic Coverage in the Essential Health Benefits Package under the Affordable Care Act

As the Secretary of Health and Human Services drafts proposed regulations implementing the essential health benefits provisions of the Patient Protection and Affordable Care Act ("ACA" or "Affordable Care Act")[i], it is important that policy-makers and regulators understand basic benefits such as orthotics and prosthetics ("O&P"). Appropriate O&P care can mean the difference between a life of disability and dependency and a life of full function, self-sufficiency, and independence. For many people, rehabilitative and habilitative services and devices are equivalent to heart surgery to a person with a cardiac condition—both are *essential* medical interventions.

"Orthotics" are orthopedic braces used to correct functional deficits in patients as a result of disease, disability or injury that affects the limbs or spine. "Prosthetics" are artificial limbs used to replace limbs lost to amputation from trauma, disease, or missing from birth. Appropriate coverage of these devices and complimentary services is critical so patients may maximize their functional abilities, rehabilitation potential, and regain independent and product lifestyles. The term "rehabilitative and habilitative services and devices" in Section 1302 of the ACA must incorporate coverage for artificial limbs (prosthetics) and customized bracing (orthotics) so those in need of O&P care may access these vital services.

There are more than 1,700,000 people in the United States living with limb loss.[ii] Every year, more than 130,000 people in the United States undergo amputation of a limb.[iii] A comparable number of Americans experience strokes, spina bifida, cerebral palsy or other impairments which are chronic, recurring, or lifetime in nature and require the use of orthoses. In addition, U.S. military personnel serving in Iraq and Afghanistan and around the world have sustained traumatic injuries resulting in amputation and musculoskeletal injuries resulting in the need for prosthetic and orthotic care.

Inclusion of O&P services and devices in the essential health benefits package under the Affordable Care Act is a critical issue to people with disabilities and chronic conditions. It will determine whether insured persons have their needs met when confronted with an illness, injury, disability, or other health condition, allowing that person to speed recovery, improve functioning, live more independently and return to work; or, alternatively whether they will be forced to pay out-of-pocket for needed care, go without needed care, or ultimately exit the private market altogether with no choice but to enter the publicly supported programs such as Medicare and Medicaid, as many children, adults, and seniors with disabilities do today.

Congress Clearly Intended "Rehabilitative and Habilitative Services and Devices" to Include Orthotic and Prosthetic Care

After extensive advocacy efforts lead by the disability community, the term "rehabilitative and habilitative services and devices" was adopted into the ACA. This term is rarely used in private health plans' benefit packages. It was created by Congress to describe a category of care intended to be considered essential. Early drafts of the Senate HELP Committee bill did not include the term "devices" and many disability groups pressed for specific inclusion of this term. Senior HELP Committee staff at the time assured the disability community that the rehabilitation benefit category was intended to cover both services (e.g., physical therapy, occupational therapy, speech language pathology) as well as devices (e.g., durable medical equipment, prosthetics, orthotics, and related supplies). Nonetheless, after continued advocacy and tremendous assistance and support from Senator Harkin and his staff, the HELP Committee added the words "and devices" to this category of essential benefits in the final HELP Committee bill.

This full term—rehabilitative and habilitative services and devices—was then adopted in the version that Senator Reid and his staff melded into the final Senate bill that went to the floor and was ultimately passed with a 60 vote margin.[iv] This came after extensive advocacy efforts by the disability community with Finance Committee members and staff as well as with Senate leadership offices.

The House version of the bill, however, still contained the term "rehabilitative and habilitative services"—with no specific reference to devices—in its essential benefits package when the Tri-Committee bill was first released during the health reform debate. Knowing that this term was intended to include durable medical equipment, prosthetics, orthotics and supplies, the disability community worked closely with the three committees and succeeded in getting a specific category added to the bill during the House Education and Labor Committee mark-up. The marked-up bill kept the category "rehabilitative and habilitative services" but then added another category for "durable medical equipment, prosthetics, orthotics and related supplies." The disability community supported this language because it made absolutely clear that these devices were covered in the essential health benefits package, consistent with congressional intent.

Congressional staff informed disability community leaders that this was possible because the Congressional Budget Office ("CBO") had informed the Committee that its estimate of specifically adding this term to the benefit package would not cost anything. CBO explained that its scoring of the original benefit package *assumed coverage of DME, prosthetics, orthotics and supplies*, and, therefore, adding a specific reference to this category to the bill did not increase the cost of the benefit. This is a key reason the House Tri-Committee bill that went to the House floor adopted this same language that specifically included coverage of the category of "durable medical equipment, prosthetics, orthotics and related supplies."

In the end, Congress did not have the votes to pass a House-Senate conferenced bill and, therefore, passed the Senate version of the Affordable Care Act.[v] This codified in the ACA's essential health benefits package the language of the Senate bill, namely, "rehabilitative and habilitative services and devices." There are no committee reports to further indicate what Congress specifically meant by this category but there is important legislative history in the form of two floor statements delivered at the time the House passed the final bills. Chairman George Miller (D-CA) and Congressman Bill Pascrell (D-NJ) spoke on the essential benefits package and their statements are the clearest form of what Congress intended as the meaning for the term "rehabilitative and habilitative devices":

> "The term "rehabilitative and habilitative devices" includes durable medical equipment, prosthetics, orthotics, and related supplies. It is my understanding that the Patient Protection and Affordable Care Act requires the Secretary of Health and Human Services to develop, through regulation, standard definitions of many terms for purposes of comparing benefit categories from one private health plan to another. It is my expectation "prosthetics, orthotics, and related supplies" will be defined separately from "durable medical equipment."[vi]

Moreover, the ACA statute requires the essential health benefits package to meet certain criteria critical to those with disabilities and chronic conditions[vii]:

> a. An "appropriate balance" among the ten categories of essential benefits. [This is, in part, a prohibition of unreasonable restrictions and exclusions in one benefit category (e.g. prosthetic or orthotic care) if similar restrictions are not placed on other categories];
>
> b. Benefit design that does not discriminate against and takes into account the health care needs of persons with disabilities. [This language provides a strong counterbalance to the general limitation regarding the typical employer plan.];
>
> c. Essential benefits are not subject to denial to individuals against their wishes on the basis of the individual's present or predicted disability, degree of medical dependency or quality of life. [This is powerful language designed to ensure that normative judgments about the quality of life of a person with a disability are not used against people with disabilities when setting the essential benefits package.]

A detailed analysis of the ACA statute and legislative history clearly establishes that O&P services and devices fit precisely into the definition of the term "rehabilitative and habilitative services and devices" and the ACA's mandate to appropriately meet the needs of people with disabilities and chronic conditions.

Typical Employer Plans Include Orthotic and Prosthetic Care

The ACA states that the scope of the essential benefits package is equal to that of the "typical employer plan."[viii] The U.S. Department of Labor ("DOL") is required to submit a report to the HHS Secretary on the contents of the typical employer plan. That report was sent to the Secretary on April 15, 2011.[ix] While most private insurers and virtually every publically supported health program cover O&P care, the DOL report dramatically underestimated coverage of these services and devices. An analysis of the report uncovers several reasons for this underestimation.

In their review of the data, DOL only considered whether certain benefit terms were listed in the employer plan documents examined in the DOL sample. Therefore, if a plan document did not mention a term, such as prosthetics or orthotics, the DOL could not confirm coverage or a lack of coverage. For example, according to the DOL Report, "prosthetics" was only mentioned in 46 percent of the plan documents examined. Therefore, in over half of the plans studied, DOL deemed it impossible to determine what coverage policy—if any—those plans had for artificial limbs. In contrast, analyses of data conducted by non-government entities on prosthetics coverage in typical employer plans revealed very different results.

In January 2011, the America Orthotic & Prosthetic Association canvassed its member orthotic and prosthetic suppliers in seven large cities. Over two-thirds of those respondents confirmed that major employer health insurance plans cover O&P services and devices more than 80% of the time, with a composite national average of at least 75% of coverage for these services and devices by the same plans.

A February 2011 study conducted by the Society of Human Resource Management ("SHRM") yielded similar results. It surveyed employers from across the United States to examine whether they offered coverage for O&P services and devices. SHRM received responses from 1,115 employers. The data showed that 70-75% of employers provide coverage for O&P. More specifically:

- 70% of small employers (i.e., 100-499 employers) had insurance plans that covered O&P.
- 75% of large employers (i.e., more than 5,000 employees) had insurance plans that covered O&P.

All federally supported health programs include coverage of O&P care. Medicare Part B covers orthotics and prosthetics, including artificial limbs and eyes; braces for the arm, leg, back, and neck; and breast prostheses and related supplies following a mastectomy. All state Medicaid plans cover O&P care for children and most adults. The Department of Defense and the Department of Veterans Affairs offer robust O&P coverage for returning service members and all veterans with injuries, disabilities, or other conditions requiring O&P care. The Federal Employee Health Benefits Program ("FEHBP") covers O&P care under its standard and preferred benefit packages. Additionally, nineteen states have passed laws ensuring that people with limb loss have fair and appropriate access to prosthetic care under private insurance and seven states have included orthotics is those laws as well.[x]

Qualifications for O&P Care Providers

O&P care is often confused with durable medical equipment ("DME") but the two fields are actually very different. O&P care is highly clinical and service-oriented, requiring a high level of education, training, and skill. All prosthetics and most orthotics are designed, fabricated and fit to meet the unique needs of O&P patients. This level of customization is very different from the field DME. Quality orthotic and prosthetic care is practiced by qualified professionals. A certified orthotist or prosthetist must meet the following criteria:

- Baccalaureate degree in orthotics or prosthetics from an accredited education institution, or Baccalaureate degree and post-Baccalaureate certificate program in orthotics or prosthetics accredited by the Commission for the Accreditation of Allied Health Education Programs and state licensure, if appropriate;
  - O&P education is transitioning toward a Master's Degree requirement
  - Five programs already require a Master's Degree
- One-year clinical residency program under a duly certified professional in each specific discipline of study at a residency site accredited by the National Commission of Orthotic and Prosthetic Education;
- Completion of a series of national certification examinations; and
- Mandatory continuing education for certification (orthotists and prosthetists must obtain 75 continuing education units (CEUs) every five years to maintain their board certification).

Members of the O&P profession play an important role in returning people to functional, fulfilling lives through the services they provide. Their specialized care is unique beyond the service aspect, in that the devices provided become a vital part of the patient's ability to remain functional and independent on a daily basis. Orthotists and prosthetists work closely with physicians boarded in physiatry, family practice, pediatrics, neurology, and endocrinology as well as orthopedic, plastic, and vascular surgeons. Other members of the rehabilitation team include physical therapists, occupational therapists and other providers of care.

The orthotist or prosthetist remains involved throughout the rehabilitation process with necessary follow up visits for patient training in the proper use of the device or for adjustments to the O&P device as the patient's condition changes. Modifications to the orthosis/prosthesis are often necessary with all patients but are usually more frequent with new patients as physiological changes can occur rapidly. This post-fitting care enhances the potential for patients to function at their highest possible level on an ongoing basis by ensuring that prostheses and orthoses are continually adapted to meet the changing functional and clinical needs of patients as they progress through rehabilitation and, ultimately, through life.

The Positive Impact of Offering Coverage for O&P Services and Devices

The demand for O&P services continues to grow with the aging of America. The total number of persons who use orthotics is expected to reach 7.3 million by the year 2020.[xi] Also by 2020, the total number of persons with an amputation is expected to reach 2.4 million.[xii]

There are several forces behind this increase. By 2050, it is estimated that 29 million Americans will have diabetes.[xiii] Those with diabetes are ten times more likely to undergo an amputation and more than 60 percent of non-traumatic lower-limb amputations are due to diabetes.[xiv] In addition, the prevalence of arthritis is rising, with the Centers of Disease Control and Prevention projecting that 67 million Americans will have arthritis by 2030. The increase in stroke survival and recovery creates a population of individuals with long-term physical disabilities, often requiring orthotic services. Finally, war injuries are difficult to forecast into the future but amputations and musculoskeletal injuries have been significant over the past decade. With a rapidly growing number of Americans requiring O&P services and devices, access to clinically appropriate O&P care by qualified professionals is critical.

Providing O&P services and devices is not only essential for those individuals who have functional deficits, it is also cost-effective. The financial impact of offering O&P services has been shown to be either exceedingly small or result in a net positive outcome.[xv] States in which prosthetic and/or orthotic "parity" laws have been enacted—laws that require fairness in O&P benefit coverage—have found there to be minimal or no increases in insurance premiums. These laws have also been shown to help reduce Medicare and Medicaid costs.[xvi] Further, state parity bills involve absolutely no outlay of any federal funds. As an example, in Colorado, the data show that covering prosthetics in all private insurance plans subject to state law cost less than twelve cents per month, and that when cost savings from avoidance of co-morbid conditions are factored into the analysis, covering O&P actually saves the state more money that it costs.

Further, in states where prosthetic and/or orthotic parity legislation has been enacted, amputees and those with limb impairments are able to obtain the prosthetic and orthotic care they need and return to a productive life. State funds have been saved, and the health insurance payers have not been

significantly impacted. Finally, O&P care allows people with disabilities to return more quickly to their preexisting employment status and continue to add to the tax base.

Conclusion

Few, if any, Americans could conceive that any credible health care plan would not cover an artificial limb for an amputee, or a customized orthotic brace for a person with Multiple Sclerosis. Few would think a meaningful health insurance plan would not replace an orthosis or prosthesis due to a significant change in the patient's condition such as a significant change in weight, height or clinical circumstances. Yet, unless O&P care is specifically included in the regulations for the essential health benefits package, these patients could be left without appropriate prosthetic and orthotic treatment, placing many people at risk of unnecessary disability, as well as co-morbid conditions with costly complications.

For more information, contact Peter W. Thomas, Counsel, O&P Alliance, at 202-466-6550.

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[i] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 129 (2010).
[ii] Insurance Fairness for Amputees Act of 2011, S. 773, 112th Cong. (2011).
[iii] Id.
[iv] S.Amdt. 2786 to H.R. 3590, the Patient Protection and Affordable Care Act.
[v] Pub. L. No. 111-148.
[vi] Representative Miller (CA). Congressional Record 156:43 (March 21, 2010) p. H1881-1884; Representative Pascrell (NJ). Extension of Remarks, Congressional Record (March 23, 2010) p. E462-463.
[vii] Pub. L. No. 111-148 § 1302 (b)(4).
[viii] Pub. L. No. 111-148§ 1302 (b)(2)(A).
[ix] Department of Labor. "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services ." (Apr. 15, 2011).
[x] Arkansas, California, Colorado, Indiana, Iowa, Illinois, Louisiana, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, Oregon, Rhode Island, Texas, Utah, Vermont and Virginia.
[xi] American Academy of Orthodists and Prosthetists. "O&P Trends and Statistics." *Available at* http://www.opcareers.org/assets/pdf/TrendsFINAL.pdf.
[xii] Id.
[xiii] Id.
[xiv] Id.
[xv] American Orthotic and Prosthetic Association, AOPA Facility Members Study (September 2010).
[xvi] Insurance Fairness for Amputees Act of 2011, S. 773, 112th Cong. (2011).