



**American Orthotic &
Prosthetic Association**

American Healthcare Act (AHCA): Orthotics and Prosthetics

Background

Most are certain that their health insurance plan, prior to the Affordable Care Act (ACA), would cover artificial limb(s) if someone in their family had an amputation and that this same insurance plan would cover customized bracing if, for instance, a family member was born with spina bifida, and developed cerebral palsy or multiple sclerosis. However, that was not always the case, and even though the ACA was certainly far from perfect, and, at minimum, would require significant revisions, it did provide some much needed protections and coverage for people with limb loss and limb impairments.

The subsequent legislative process used to repeal /revise the ACA through the AHCA is also not ideal, and has left important ambiguities unanswered, raising important concerns among the orthotics and prosthetics field and the patients they serve. Most notable among these are: (a) the number of insured Americans; (b) certainty of national standards for essential health benefits; (c) premium protections for pre-existing conditions may become options; and (d) the prospect of substantial reductions in Medicaid funding/payments .

Essential Health Benefits

We are concerned that the removing of certain essential health benefits from insurer plans may cause individuals to face the possibility of not having coverage for orthotics and prosthetics (bracing and artificial limbs), or be faced with unrealistic annual limits or artificial lifetime caps.

Orthotics and prosthetics are considered an essential health benefit under the rehabilitative and habilitative services and devices category; in part because it was included in a majority, not all, of private payer plans. In 2011 The Society of Human Resource Management (SHRM), the world's largest HR organization with over 250,000 members conducted a survey relating to employer plan availability of O&P services, securing responses from a subset of its membership falling into two categories: (a) large employers with 5,000 or more employees, and (b) smaller organizations with between 100 and 499 employees. Based on 1116 responses they received, at least 75% of large private employer plans, and 70% of the smaller private employer plans offer coverage for artificial limbs and customized bracing, i.e., prosthetic and orthotics, with a margin of error for this sample of +/- 3%.

If essential health benefits are removed we could return to 25-30% or more of private employer plans not covering orthotics and prosthetics, and possibly even an increase in the number of non-employer based plans not including O&P coverage.

In addition prior to the ACA only approximately 20 states had enacted state-level orthotic and prosthetic parity laws. Most of these laws state that if an insurer offers O&P coverage, that it must be on the same terms as the policy's general medical and surgical coverage (these bills typically are not mandates of coverage, but rather set a minimum standard of what must be offered if the insurer is to present its plan as including O&P benefits). In states that didn't have these protections patients were faced with limits/caps, like one artificial limb per life; even if Medicare has stated that there is not an established limited useful lifetime for prosthetics. The absence of O&P services being within essential health benefits protections would likely mean that a larger number of our patients would not have insurance coverage, and so could be detrimental to both the care of those patients as well as the revenue stream for O&P businesses/practices.

Pre-Existing Conditions

We are concerned that the AHCA provision under which premium protections for those with pre-existing conditions could be eliminated as a matter of state-level waiver could result in select/targeted individuals losing access to affordable and necessary coverage.

Insurance companies are currently prohibited from either discriminating against, or charging a higher premium to individuals who may have a pre-existing condition. However, it appears that new waiver provisions in the AHCA could operate to remove the pre-existing condition protections, thus allowing insurance companies to once again charge individuals higher premiums, because of a pre-existing condition or deny them coverage.

Amputations which are traumatic or caused by an accident, may not always be considered a pre-existing condition, however if the amputation and all follow-up care is required as a result of a disease (non-traumatic); then it could be considered as a pre-existing condition. For example, diabetes may be curable but can also be a long-term illness and lead to an amputation; and cause insurance companies to declare the amputation as a pre-existing condition. A large number of individuals have been affected by the burdens caused by diabetes, in 2010 29.1 million individuals were diagnosed with diabetes and in 2010 60% of non-traumatic lower-limb amputations among adults were attributed to people with diabetes.

There are also several conditions (e.g. cerebral palsy or multiple sclerosis) currently listed as pre-existing, and life lasting, which may result in some type of limb impairment and require the use of an orthosis. With the increasing complexity and cost of certain orthosis and the time and care required to treat these conditions, these patients could also face a significant burden and perhaps absence of coverage if the premium protections for patient with a pre-existing condition were eliminated in a specific state.

The AHCA does include a provision which would add set aside funds to address the possible impact of premium increases and/or create "high-risk pools" for those with pre-existing conditions, however it is believed that funds set aside would likely not prove enough to limit major premium increases for most individuals with pre-existing conditions. It has also been stated that a lot of times individuals in "high risk pools" may face lifetime or annual limits, and this can cause individuals not receiving the care they need or deserve; again reducing the quality of coverage, if any, for these patients, and thereby also financially impacting the O&P care provider.

Expansion of Coverage

We are concerned that the essential services, orthotics and prosthetics, provided through Medicaid to millions of individuals are at risk within the current framework of healthcare legislation reform.

It is estimated that the uninsured rate fell from 18.2% in 2010 to 10.5% in 2015, and this drastic drop was mostly of a result of the expansion of the Medicaid programs. This expansion was vital to amputees and the facilities who treat them. In 2013, around the time the Medicaid expansion was in full effect, the recorded number of amputations (upper and lower extremity) was 154,000 and 14% of those were paid by Medicare; as compared to 18% by private payers.

The 2016 AOPA Performance & Compensation indicated that in 2015, AOPA members reported that approximately 16% of their overall billing/payments were from Medicaid. Removing/altering this stream would place a burden on O&P facilities, already facing financial crunches and burdens due to unrealistic audits and reviews by private payers and Medicare.

The original Congressional Budget Office (CBO) score found that the AHCA would cut Medicaid funding by \$880 billion over 2017-2026. This reduction and some of the proposed methods of closing the gap, would most likely result in high costs being shifted to states and/or families who would be unable to handle the additional costs of care without significant federal intervention. In addition, as a way to save money the states may be inclined to cut funding/reduce payments and services, placing patients in harm's way, for example moving to status as uncompensated care, and thereby potential placing a financial burden on the O&P provider.

Besides the loss in funding to the expanded Medicaid programs the original CBO score for AHCA also stated that approximately 24 million individuals would lose their coverage over the next 10 years. Since, the majority of amputations are between the ages of 45-64, the time before someone becomes eligible for Medicare, and the fact that not all private payers cover prosthetics, the loss of Medicaid expansion could be detrimental to patients facing limb loss and already suffering from limb loss. .

Recommendation

It has been demonstrated that proper and prompt O&P care can save money and lives, and we want to ensure that patients with limb loss or limb impairments will not be excluded from any healthcare plans and will continue to have access to the highest quality of care they have become accustomed to and deserve.

We encourage Congress to listen to all stakeholders (patients, orthotists, prosthetists, doctors, hospitals, insurers, trade associations, etc.) to ensure that any new healthcare legislation includes affordable choices for all and doesn't remove coverage from those who may need it most.

For more information contact the American Orthotic & Prosthetic Association (AOPA) at (571) 431-0876 or www.AOPAnet.org.