Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council

House Bill 317
Prosthetic Devices

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EXECUTIVE SUMMARY

The Pennsylvania Health Care Cost Containment Council is required to review current or proposed mandated health benefits on request of the executive and legislative branches of government [Section 9 of act 14 of July 17, 2003 (P. L. 31, No. 14) (Act 14)]. The Council's role in conducting reviews of this nature is primarily to determine if sufficient evidence is available to proceed to a more formal Mandated Benefits Review Panel as outlined in Act 14, which includes contracting with a panel of outside experts to review the scientific validity of the studies submitted. Documentation would be deemed sufficient if it met the necessary requirements for the Panel to fulfill their duties and responsibilities which include: (1) review of the documentation submitted by opponents and proponents, (2) report to the Council on whether the documentation is complete with regard to the eight information categories described in Act 14, whether the research cited meets professional standards, whether all relevant research has been cited in the documentation, and whether the conclusions and interpretation in the document are consistent with the data submitted. Act 14 places the burden of providing scientific data and information regarding the proposed mandate on interested parties. While the Council conducts its own research as appropriate, the reviews rely almost entirely upon outside information as detailed in the enabling legislation.

This document presents the results of the Council's review of House Bill 317, which would require that individual and group health insurance policies provide coverage for prosthetic devices and components for individuals with limb loss and would include the fitting, repair or replacement of a prosthetic device and/or component.

In the case of House Bill 317, there was not sufficient information submitted to the Council to recommend the bill or to continue with a more formal review process. We note the following points, which may be of interest to the General Assembly:

- The documentation submitted to the Council confirmed the physical and social impact associated with limb loss, which is estimated to affect more than 60,000 Pennsylvania residents (or approximately 5 per 1,000 persons).

- Overall, however, the documentation submitted to the Council lacked specific financial information to fully address the costs and financial benefits that might be associated with this bill. In particular, requisite scientific studies and cost figures were not submitted to determine (1) the impact that increased insurance coverage would have on overall health care costs and (2) the expected number of people who would benefit from increased coverage and the amount of financial hardship that would be alleviated.

- The Council considers other states' experiences when conducting mandated benefit reviews. In the case of HB 317, much of the data from other states with similar legislation was prospective in nature, not retrospective analyses that detailed the actual impact of prosthetic parity on charges, costs and payments for services.

- Submissions contained conflicting statements as to how much coverage is already available for prosthetic care. Proponents of the bill stated that the existing caps private insurance companies have in place are unrealistic, and that current limitations and exclusions render coverage inadequate. Opponents who submitted information noted that, while certain limits and caps exist, they are already providing coverage for medically necessary prosthetic devices, components, repairs and replacements. These

conflicting statements were not reconcilable due to the insufficient nature of the information provided to the Council.

- While there appear to be secondary benefits to providing coverage (e.g., preventing heart disease, obesity, additional amputations, etc.), not enough documentation was provided to quantify these benefits. One important point centers on diabetes. Proponents of the bill point out that amputees without prosthetic care tend to lead more sedentary lifestyles, which can lead to costly secondary complications, such as diabetes. Yet, according to the Centers for Disease Control and Prevention, diabetes is the leading cause of lower-extremity amputation in the United States and not the other way around. In this regard, perhaps continued efforts are needed to better diagnose, prevent and manage diabetes. In 2006, 3,361 Pennsylvania residents underwent a lower-extremity amputation in a Pennsylvania hospital. Approximately 58.8% had a diagnosis of diabetes.

- Based on PHC4's analysis, the estimated costs of providing prosthetic devices for a "start-up" year ranged from a low of $1,937,000 to a high of $6,160,000. Estimated annual replacement costs for prostheses under this mandate ranged from a low of $21,976,000 to a high of $59,360,000. For both the "start-up" year and replacement costs, a 75% utilization rate was assumed. It should be noted that while the legislation also calls for coverage of fittings and repairs of prosthetic devices and/or components, the Council was unable to estimate projected costs for these services as no documentation was submitted from proponents or opponents on these costs nor does PHC4 collect this data from providers.

- In reference to concerns about mandated benefits in general, the Council agrees with an important point raised, which is that insurers should be able to tailor their products so low-income individuals can access basic coverage at an affordable price. A few insurers noted that while most of their policies include prosthetic coverage, the ability to offer such coverage as an optional benefit and to allow purchasers to tailor benefit packages is essential as the needs of individual and group customers vary.

- Finally, the Council considered this legislation in light of concerns raised about the cumulative effect of all health care mandates in Pennsylvania. Citations that highlight this impact include:

  Health Insurance Mandates in the States: 2007 (Council for Affordable Health Insurance, March 2007)
    - Mandated benefits increased the costs of basic coverage from slightly less than 20% to more than 50%, depending on the state (over 1,900 mandates analyzed).

  Mandated Benefits Laws and Employer-Sponsored Health Insurance (Health Insurance Association of America, January 1999)
    - As many as one in four people are uninsured because of the cost of state health insurance mandates.

REVIEW OF HOUSE BILL 317

Overview of Bill

House Bill 317 would mandate that individual and group health insurance policies, except to the extent already covered under another policy, provide coverage for prosthetic devices and components if prescribed by a health care professional legally authorized to prescribe such items under law. Such coverage would include the fitting, repair or replacement of a prosthetic device and/or component for individuals with limb loss if the item is determined to be medically necessary. "Limb" is defined as an arm, hand, leg, foot or any part of one of these appendages. An insurer may require prior authorization to determine medical necessity. An insurer also may require that prosthetic services be rendered by a provider that contracts with the carrier and that a prosthetic device or component be provided by the insurer's designated vendor. Coverage is not required for prosthetic devices designed exclusively for athletic purposes. It should be noted that House Bill 317 would not mandate coverage for orthotic devices.

Mandated Benefits Review Process

PHC4's enabling legislation, Act 89 of 1986 (as re-authorized by Act 34 of 1993 and Act 14 of 2003), provides that PHC4 review current law or proposed legislation regarding mandated health benefits when requested by the executive and legislative branches of government. Representative Anthony DeLuca, Chairman of the House Insurance Committee, requested that PHC4 review the provisions of House Bill 317, PN 358. Representative Bernie O'Neill is the bill's prime sponsor.

Notification was published in the *Pennsylvania Bulletin* on July 14, 2007, requesting that interested parties submit documentation and information pertaining to House Bill 317 to PHC4. Letters also were sent to potentially interested individuals and organizations informing them of the pending review and inviting them to submit information pursuant to the notice. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit additional comments. Final submissions were due to PHC4 on October 30, 2007. The Pennsylvania Department of Health and the Insurance Department were notified of the review and received a copy of the submissions.

A list of the submissions received is attached.

Act 14 provides for a preliminary PHC4 review to determine if the documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This formal process involves another step beyond PHC4's review by contracting with five additional experts to review the documentation submitted by proponents and opponents.

This report presents the results of PHC4's preliminary review and conclusions regarding whether the material is sufficient to proceed with the formal review process.

Analysis of Documentation Submitted by Opponents and Proponents in Response to the Eight Categories Required by Act 14, Section 9

I. The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.

Affected population. The Amputee Coalition of America (ACA), the leading national advocacy group for people with limb loss and limb difference, reported that the nation's prevalence rate for amputation is 4.9 per 1,000 persons. Based on this rate, ACA estimated that there are 60,959 amputees in Pennsylvania. Using state insurance demographics, ACA further estimated that 37,014 amputees are covered by private insurance. Highmark cited a 2006 fact sheet from the National Limb Loss Information Center (NLLIC), which reported that approximately one out of every 200 people (or 5.0 per 1,000 persons) in the nation is an amputee. Based on this figure and Pennsylvania's estimated 2006 population (12,440,621), the number of amputees in the Commonwealth could be estimated at 62,203. Another estimate presented by the Pennsylvania Council on Independent Living indicated a higher number (83,278) of Pennsylvanians affected by limb loss.

Referencing the NLLIC fact sheet, Highmark also noted that while the rates for cancer and trauma-related amputations are decreasing, rates for dysvascular amputations (i.e., those related to complications of the vascular system, particularly caused by diabetes) are increasing. Over the past three decades, the incidence of congenital limb deficiency has remained stable.

Availability. Most submissions addressed availability as it relates to insurance coverage, which is included in section (II) below. Some submissions, however, noted the prices for which these devices are available. Referencing a 2005 New Jersey study of a similar bill, Highmark reported that costs of prosthetic devices typically range from $3,000 to $40,000. However, there are some computerized devices that cost more than $70,000. Highmark also included other statistics that cite the costs of below-the-knee prosthetics at $6,000 to $8,000 and prosthetic arms or legs above the knee at $10,000 to $15,000.

Using a breakdown that was developed by the California-based Amputee Services and Technical Assistance Program, the Amputee Coalition of America listed the following prices:

Lower-extremity devices

- $5,000 to $7,000 for a below-the-knee prosthesis that enables standing and walking on level ground
- $10,000 for a below-the-knee prosthesis that enables traveling up and down stairs and walking on uneven ground
- $12,000 to $15,000 for a prosthetic leg that enables running and functioning almost on par with someone with two legs
- $15,000 or more for devices with polycentric mechanical knees, swing-phase control, stance control, and other mechanical or hydraulic systems
- $20,000 to $30,000 starting prices for computer-assisted devices

Upper-extremity devices

- $3,000 to $5,000 for a nonfunctional cosmetic hand
- $10,000 for transradial prosthesis, which is a “split hook” below-the-elbow device
- $20,000 to $30,000 for realistic myoelectric hands that open and close

Utilization. Blue Cross of Northeastern Pennsylvania (BCNEPA) included national data regarding the number of individuals using assistive technology in 1994, which seems to be the last year the Centers for Disease Control and Prevention (CDC) updated this information. According to the CDC, in 1994, 199,000 used an artificial limb of any type, of which 173,000 (87%) used an artificial leg or foot, and 21,000 (11%) used an artificial arm or hand.

The Amputee Coalition of America (ACA) reported that this legislation will not increase utilization, just availability, unlike many other mandated benefits. Yet, ACA did cite two main reasons for curtailed or limited use of prosthesis. Stump irritations or sores are one reason. ACA maintains that, without appropriate coverage, many amputees are forced to wear ill-fitting or worn devices, which cause these irritations and sores. Fear of falling is another reason for limited use. ACA noted that this is a common fear for amputees who are not given the most appropriate device. Therefore, given this assertion that some amputees currently have to limit their use of prostheses, it can be assumed that legislation enabling more repairs and replacements would increase utilization for those who are living with ill-fitting, inappropriate or worn devices.

Highmark noted that when a benefit is mandated, there is usually a correlating increase in utilization of that benefit. However, in the case of House Bill 317, Highmark stated that it would experience minimal change in utilization due to the prosthetic coverage it already provides.

Blue Cross of Northeastern Pennsylvania (BCNEPA) reported that it could not identify specific prosthetics utilization for its customers as prosthetics comprise part of the organization’s overall durable medical equipment utilization.

II. The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.

Existing coverage. Automobile insurance, worker’s compensation insurance, government health programs (e.g., Medicare, Medicaid, Veterans Health Administration and TRICARE), some state vocational rehabilitation and technology assistance programs, specialty nonprofit organizations, and some private insurance companies provide coverage for prosthetic devices.

The Insurance Federation of Pennsylvania found that almost all commercial major medical health insurance products cover initial prosthetic devices if they are medically necessary. However, among insurers, there are more limitations and exclusions with respect to replacements. As such, the Federation stated that the main question raised by this bill is “whether the exclusion of or dollar limitations on replacement or upgraded prostheses cause inadequate health care or financial hardships for Pennsylvanians.”

The Amputee Coalition of America (ACA) stated that the existing caps private insurance companies have in place, such as one limb per lifetime, $2,500 per lifetime and $500 per year, are unrealistic, and the purpose of this bill is to overcome such limitations and exclusions, which render coverage inadequate. ACA also noted that some insurers are reducing prosthetic coverage or eliminating it altogether. In a 2007 online ACA survey, 29% of respondents indicated that their prosthetic coverage had been reduced, and 8% indicated that it had been eliminated. While respondents may have been asked to identify their insurer, ACA's submission did not identify which insurers had reduced/eliminated coverage with respect to this poll. As part of another national survey on prosthetic coverage restrictions, ACA did identify several health insurers operating in Pennsylvania that are restricting access to prosthetic care, along with the coverage restrictions. However, as this was a national survey, it was not clear whether the restrictions listed applied to the company's Pennsylvania line of business.

The Pennsylvania Council on Independent Living (PCIL) indicated that while Medicare routinely covers new prosthetics, replacements and repairs, coverage for individuals not Medicare eligible is "either non-existent, limited by the number of prosthetics allowed, or limited by a monetary cap, which is meager at best." As an example, PCIL noted that Commonwealth employees are covered by insurance that provides only one prosthetic per lifetime even though such devices are designed to last three to five years. (Inquiries into the prior statement revealed that, according to the Pennsylvania Employees Benefit Trust Fund (PEBTF) Summary Plan Description, replacements for prosthetics are only covered for dependent children and for breast prostheses due to mastectomy. However, PEBTF is currently exploring an expansion of its prosthetics coverage to follow Medicare replacement guidelines, which would allow replacements every five years for wear and tear or if there is a change in medical condition.)

Donald E. Hossler, a constituent with limb loss, submitted a summary of a statewide survey of prosthetic coverage restrictions that was prepared for the Pennsylvania General Assembly when it was considering similar legislation in 2006. Conducted by ACA and Hanger Orthopedic Group, the survey found a variety of ways that insurers are limiting coverage:

Summary of Coverage Restrictions among Various Pennsylvania Insurers

Financial Restrictions	Exclusions	Co-Pays
$5,000 cap per year	Coverage for repairs	50% co-pay
$1,000 cap per year	Coverage for replacements	
1 prosthesis per lifetime	A max out on benefits if the patient had received a prosthesis from another insurance company	
$2,500 cap per calendar year	20% reimbursement	
50% of cost for DME		
$2,500 max lifetime cap		
$7,000 max lifetime cap		

Independence Blue Cross noted that all of its fully insured policies provide coverage for medically necessary prosthetic devices, components, repairs and replacements. Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that its current medical policy provides

coverage for prosthetic devices up to $5,000 per year (with an option for $10,000 per year). Devices have to be deemed medically necessary by a physician.

Capital BlueCross noted that while it provides a few products that exclude coverage for prosthetics, medically necessary prosthetics and components are generally part of the standard benefit. Capital BlueCross covers fittings, adjustments, repairs and replacements of prosthetic devices, which replace all or part of an absent or permanently inoperative organ or malfunctioning body part. Devices designed for athletic purposes are not covered. Replacement of devices or parts would be eligible for coverage if the patient's physiological condition changes; the device or part cannot be repaired; or repairs to the device or part would be more than 60% of the new cost of a new device or part. While there are no set limits on the number of devices a member may receive, Capital BlueCross may require preauthorization and that a participating provider render services. In its submission, Capital BlueCross did not identify specific financial limits on coverage, but it noted that, in all instances, a member's contract will determine what benefit limits may apply.

Highmark noted that its health benefit plans (indemnity coverage, managed care coverage, indemnity Medicare supplement, and Medicare managed care plans provided through its subsidiary Gateway Health Plan) offer coverage for prosthetic devices, and the devices covered by its policies typically are broader that those included in House Bill 317. One example follows:

> [Highmark's] traditional comprehensive indemnity plan covers the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Although House Bill 317 does not include coverage for breast prostheses, this plan covers the initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof. In some cases, benefit maximums per benefit period may apply.

While Highmark did note that benefit maximums may apply, it did not identify specific financial limits on coverage.

Inadequate care. The Amputee Coalition of America (ACA) stated that lack of coverage can lead to other medical conditions, such as flexion contractures, skin breakdown, osteoporosis, muscle loss and depression, and can lead to increased reliance on nursing home and/or home care.

Benchmark Medical, Inc., which operates two prosthetic-orthotic clinics in Pennsylvania, noted that patients who cannot afford basic devices can develop co-morbidities, which require other treatment that is covered by insurance, but would not have been necessary if prosthetic coverage was adequate. Benchmark cited obesity, complications from cardiovascular conditions and mental health issues as some of these conditions. However, specific cost-saving figures related to these co-morbidities were not included in its submission. Benchmark listed decubitus ulcers, muscle contractures, additional amputation, muscle loss and bone density loss as secondary complications.

The Insurance Federation of Pennsylvania argued that the variations in prosthetic coverage do not result in inadequate health care, as virtually all commercial products cover initial devices and "the provision of a prosthesis meeting current standards at the time of injury is

clearly an adequate response to the patient's needs." The Federation also noted that "[a] system which supplies that can hardly be deemed inadequate, notwithstanding occasional disagreement over features or appurtenances of the initial fitting."

Financial hardship. In terms of financial hardship, the Amputee Coalition of America (ACA) stated that insufficient coverage can shift costs to the public sector, which has to spend more on unemployment programs, employment and training programs, and rehabilitation and counseling programs. In "Prosthetic Coverage is Good Medicine for Working Families," ACA noted that every dollar spent on rehabilitation, including prosthetic care, can save more than $11 in disability benefits. Furthermore, when families do not have adequate prosthetic coverage, they often have to mortgage their home, get bank loans, use college and retirement savings, use high-interest credit cards or cost shift to the state to get a device from Medicaid.

The Pennsylvania Council on Independent Living (PCIL) noted that inadequate coverage can create other financial hardships. In addition to losing a job, amputees sometimes have to spend more on wheelchairs, home modifications, vehicle modifications, increased medical complications, homemaker services, and personal assistance services. PCIL stated that personal assistance services cost approximately $17 an hour.

The Insurance Federation of Pennsylvania wrote that since insurers are not systematically excluding coverage for initial prostheses, there is not a case for claiming widespread financial hardship.

None of the above entities provided specific figures, (e.g., number of persons experiencing these difficulties or needing personal assistance services) that could be used to estimate financial hardship.

III. The demand for the proposed benefit from the public and the source and extent of the opposition to mandating the benefit.

Support for House Bill 317. In support of the mandate, PHC4 received submissions from the American Orthotic and Prosthetic Association, Amputee Coalition of America (ACA), Pennsylvania Council on Independent Living, Pennsylvania Orthotic and Prosthetic Society, three prosthetics practitioners, an amputee support group, a family physician, and two persons with limb loss. Thirty-nine individual constituent letters also were received. Within its submission, ACA forwarded additional letters of support from the Amputee Support Team, the Eastern Amputee Golf Association, Carter Orthopedics, Ltd., the Orthotic & Prosthetic Assistance Fund, Inc., St. David's Episcopal Church in Wayne, PA, and a copy of the letter submitted separately from the Pennsylvania Orthotic and Prosthetic Society.

As evidence of the demand for this benefit, ACA – the nation's leading advocacy group for amputees – pointed to the strong push nationally for prosthetic parity legislation. ACA listed seven states (California, Colorado, Maine, Massachusetts, New Hampshire, Rhode Island and Oregon) as having prosthetic parity laws, and 28 others as working to pass such legislation. [Note: In its submission, the Insurance Federation of Pennsylvania reported that, in Maryland and Michigan, prosthetic coverage is mandated for nonprofit Blue plans.] ACA is also working with the U.S. Congress to introduce a prosthetic parity bill at the federal level.

Additionally, ACA noted that it has strong support from a wide range of partners, including the American Academy of Family Physicians, American Diabetes Association, American Cancer

Society, American Medical Association, American Nurses Association, American Congress of Rehabilitation Medicine, American Physical Therapy Association, and various state and national professional organizations representing prosthetists. Within Pennsylvania, ACA has collected more than 1,260 signatures in support of House Bill 317. However, no documentation was received from these signatories.

ACA stated that, in return for premiums paid, people with limb loss should be able to access prosthetic services, which provide basic medical care for what is a catastrophic injury. It further noted:

> Given that prosthetic care is not only restorative, but also prevents many costly and deadly secondary conditions, it should certainly be seen as a critical health service. Prosthetic coverage laws put prosthetics where they belong – on par with other critical medical services in people's health insurance plans. The general public supports this concept.

Opposition to House Bill 317. PHC4 received submissions from seven organizations (five insurers, the Insurance Federation of Pennsylvania, and the Pennsylvania Chamber of Business and Industry) that oppose mandating coverage for prosthetic care.

While not specifically opposing the mandate contained in House Bill 317, the American Family Life Assurance Company of Columbus (AFLAC) suggested that supplemental insurance policies be excluded from the bill. AFLAC argued that "[t]he role of supplemental insurance benefits is to pay cash benefits to the insured to fill the gaps between what is covered by comprehensive insurance and the total financial impact of an illness or injury" and that these policies "are not intended to be…substitutes for comprehensive, major medical health insurance."

However, the following are several key arguments against the bill that were repeated throughout the submissions: 1) mandates, in general, increase health care costs, 2) mandates limit the ability of purchasers to select benefit packages, 3) the mandate in House Bill 317 is open-ended in nature, and 4) there is currently sufficient coverage from private insurers, as well as other financial assistance, for prostheses.

- *Mandates, in general, increase total health care costs*

  Rather than ensure better health care, opponents stated that mandates increase premium costs, reduce health coverage for some individuals, and force others to become uninsured. The opponents suggest the following scenario as one of the mechanisms that increase the total cost of health care:

  - Large employers become self-insured to avoid mandates.
  - This increases the burden on medium-size and small businesses that are already struggling to provide their employees with health care coverage.
  - These smaller employers are forced to pass on the costs to their employees.
  - Employees' real wages are affected through higher contributions toward health care coverage and/or lowered hourly rates or salaries.
  - Some employees may not be able to afford the increases and join the ranks of the working uninsured.
  - Others may be laid off and join the ranks of the unemployed uninsured.
  - Either way, health care costs are increased.

Several opponents noted their concern regarding the cumulative effect of mandates since one individual mandate may have minimal cost implications. Two studies that opponents cited regarding the collective impact of all types of mandates are noted below:

Health Insurance Mandates in the States (Council for Affordable Health Insurance, March 2007)

- Mandated benefits increased the costs of basic coverage from slightly less than 20% to more than 50%, depending on the state (over 1,900 mandates analyzed).

Mandated Benefits Laws and Employer-Sponsored Health Insurance (Health Insurance Association of America, January 1999)

- As many as one in four people are uninsured because of the cost of state health insurance mandates.

- *Mandates limit the ability of purchasers to select benefit packages*

  Capital Blue Cross stated that while most of its insurance policies cover medically necessary prosthetic devices, it does offer a limited number of products that exclude such coverage. These exclusions exist so low-income individuals can access basic coverage at an affordable price. Thus, this legislation would make coverage less affordable for people who currently choose to buy a product without prosthetic coverage.

  Highmark also noted that while most of its health benefit plans offer standard prosthetic coverage, its ability to offer such coverage as an optional benefit is important as the needs of group and individual customers vary.

- *The open-ended nature of the mandate*

  Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that the mandate's open-ended nature is the focus of its cost concerns. Prosthetics, like other aspects of medicine, are constantly advancing technologically, and it is imperative that such advancements be measured against the quality of life they allow and the costs they incur. BCNEPA wrote that the open-ended benefit proposed in this legislation "eliminates this balance by calling on insurers to provide for – and for consumers to pay for – unlimited and unchecked provision, repair and replacement" of prosthetics.

  The Insurance Federation of Pennsylvania also had concerns with open-ended language in the legislation. It noted that House Bill 317 was vague in several areas and this would raise major problems during implementation. Two of the ambiguities noted were related to the primacy of coverage and qualifying medical necessity.

- *There is currently sufficient coverage from private insurers, as well as other financial assistance, for prostheses*

  Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that it has found no evidence that its current prosthetic coverage does not meet its members' needs or that members suffer hardship because its current coverage is not unlimited in nature. BCNEPA said neither it nor the state Departments of Health and Insurance have received a high number of member complaints with respect to its prosthetic coverage. According to BCNEPA, durable medical equipment provider interests are what are advancing this legislation.

In response to the claim that there are few complaints about the adequacy of prosthetic coverage, Donald E. Hossler, a constituent with limb loss, noted that an insurance company may not be aware of a member's concerns about limitations and exclusions if that member is fortunate enough to have his or her needs picked up by a spouse's insurance. If such is the case, Hossler stated, "Insurance companies then report no evidence that individuals in coverage areas are unable to access the prosthetic benefit because the exclusion/limitation has been shifted to the spouse's insurance policy."

The Insurance Federation of Pennsylvania noted that the traditional argument for a mandate – there is a deficiency in the marketplace because a service in not currently provided or reimbursed by insurers – is not the case with House Bill 317. As mentioned in section (II), the Federation's survey of health insurers revealed that virtually all commercial major medical plans cover initial prosthetic devices when medically necessary. According to the Federation, the issue raised by the legislation is one of benefit limitation, not lack of coverage.

In its submission, Highmark stated that, in addition to the coverage offered by private insurers, other options for persons needing assistance are available. While some of these options were previously discussed in section (II), Highmark cited a 2006 National Limb Loss Information Center fact sheet, which noted that prosthetic devices are covered by Medicare, Medicaid, the Veterans Health Administration, TRICARE, state vocational rehabilitation and technology assistance programs, and various nonprofit organizations.

IV. All relevant findings bearing on the social impact of the lack of the proposed benefit.

While Highmark acknowledged that the loss of a limb is very traumatic and that psychological, social, emotional and economic issues can result, it stated that the company's prosthetic coverage is "recognition that we want our members affected with limb loss to make a successful transition back to as 'normal' a life as possible." Highmark included a 2002 study from the *Journal of Prosthetics and Orthotics*, which cites depression, drug and alcohol abuse, low self-esteem, fatigue, anxiety, sexual difficulties and suicidal tendencies as psychosocial problems that some amputees may face. Highmark also included a newsletter article from the Amputee Coalition of America (ACA), which discusses how children with limb loss face both emotional and physical adjustments and need support at various stages of their development.

Georgia Foltz, a constituent with limb loss, identified several costly psychological issues generated by amputation. Foltz wrote:

> The amputee may go through a grieving process just as when a death occurs. Depression is often a factor post amputation. Family dynamics change and marriages may fail as the spouse deals with [the] altered appearance of the amputee, as well as increased financial burden, possible self imposed isolation of the amputee and anger directed at family members.

According to the Insurance Federation of Pennsylvania, efforts to gauge the social impact of not mandating prosthetic coverage are speculative. However, without citing specific studies, they did speculate that the social effects are not widespread, as long as the initial devices made available are satisfactory.

ACA indicated that the proposed benefit can improve the physical and psychological health of persons with limb loss. Prosthetic devices enable amputees to work, perform daily activities, exercise and live independently. Thus, these devices can help increase work productivity and avoid economic loss. ACA noted that while there are some private nonprofits that provide assistance, they can only assist the most impoverished amputees.

V. Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

A few submissions noted that this point is not applicable as House Bill 317 does not introduce new therapies or cover one particular type of therapy.

In its submission, Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that there have been few studies on prostheses, particularly microprocessor prostheses. According to BCNEPA, the Blue Cross Blue Shield Association's policy on microprocessor-controlled prosthetic knees concluded that:

> "[A] microprocessor-controlled knee may provide incremental benefit for some individuals. Those considered most likely to benefit from these prostheses have both the potential and need for frequent ambulation at variable cadence, on uneven terrain, or on stairs. The potential to achieve a high functional level with a microprocessor-controlled knee includes having the appropriate physician and cognitive ability to be able to use the advanced technology."

BCNEPA noted that the basic premise of its microprocessor-controlled knee policy is applicable to other devices. This premise is that more technologically advanced devices may be necessary for some – but not all – patients. BCNEPA further noted that House Bill 317 would eliminate an insurer's ability to use available medical studies to establish policies and would require insurers to provide for unlimited replacements of devices based solely on determinations by prescribing physicians.

VI. Where the proposed benefit would mandate coverage of an additional class of practitioners, the result of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

This point is not applicable as House Bill 317 does not mandate coverage for an additional class of practitioners.

However, in its submission, Highmark noted its concern about the potential for sub-par providers delivering prosthetic services to its members. It reported that some states' mandates have licensure requirements for prosthetic service providers.

The Amputee Coalition of America (ACA) pointed out that there is a national organization – the American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) – charged with accrediting prosthetic care facilities and providers. ABC practitioner certification requirements are the only standards recognized by the Commission on Accreditation of Allied Health Education Programs, the largest program accreditor in the health sciences field.

While House Bill 317 does not call for this type of accreditation, it does state that "[a] health care insurer may require that prosthetic services be rendered by a provider that contracts with the carrier and that a prosthetic device or component be provided by a vendor designated by that insurer."

VII. The results of any other relevant research.

A number of submissions provided research related to potential costs associated with prosthetic parity legislation; these results are covered in section (VIII, B).

The Amputee Coalition of America (ACA) included information related to the costs associated with not providing adequate coverage for prosthetic care; this information is included in section (VIII, A).

VIII. Evidence of the financial impact of the proposed legislation.

A. The extent to which the proposed benefit would increase or decrease cost for treatment or service.

Blue Cross of Northeastern Pennsylvania (BCNEPA) noted that its current prosthetic coverage is capped at $5,000 per year, but under House Bill 317, it would have to eliminate caps and could have to reimburse for technologically advanced devices that cost more than $70,000 a piece. A national actuary firm suggested that BCNEPA double the cost per year to account for this; thus, BCNEPA estimated that the legislation would increase the annual cost of an individual prosthetic claim from $486 to $972. However, the number of prosthetic claims per year was not provided as prosthetics are part of BCNEPA's durable medical equipment utilization.

While the Amputee Coalition of America did not provide information related to how the bill would affect the cost of prostheses, it did provide general information related to the costs associated with individuals not having prosthetic care. Amputees without prosthetic care tend to lead more sedentary lifestyles, which can lead to costly secondary complications:

- Diabetes-related complications are on the rise, and medications for these conditions can total $100 per month. If a person becomes an amputee at 55 and lives to 77, the tab for these medications would be $264,000.
- Surgical treatment and hospitalization for a heart attack brought on by peripheral vascular disease can cost from $75,000 to $200,000.
- Hip or knee problems that may develop from an inability to walk correctly can result in costs ranging from $80,000 to over $150,000 in a lifetime.
- Wrist, elbow and shoulder problems can result from crutch overuse. On average, a simple carpal tunnel surgery costs $7,500, and elbow and shoulder surgeries run $16,000 and $25,000, respectively.

However, no specific figures of how many amputees would be affected by these complications were provided.

B. **The extent to which similar mandated benefits in other states affected charges, costs and payments for services.**

As previously noted in section (III), the Amputee Coalition of America (ACA) identified seven states (California - 2006, Colorado - 2001, Maine - 2003, Massachusetts - 2006, New Hampshire - 2004, Rhode Island - 2006 and Oregon - 2007) that have passed mandates for prosthetic coverage. Several submissions cited research that was conducted by a few of these states as they were considering the legislation.

It should be noted that these enacted laws may differ in scope, such as mandating both orthotic and prosthetic coverage. ACA reported that most states chose the federal Medicare law as the minimum standard. According to the Centers for Medicare and Medicaid Services Web site, the "Medicare payment for…prosthetics and orthotics (P&O)…is equal to 80 percent of the lower of either the actual charge for the item or the fee schedule amount calculated for the item, less any unmet deductible. The beneficiary is responsible for 20 percent of the lower of either the actual charge for the item or the fee schedule amount calculated for the item, plus any unmet deductible." Medicare also covers replacements [every five years], adjustments and repairs. The Insurance Federation of Pennsylvania pointed out that the proposed mandate in Pennsylvania would be among the most generous in the nation.

- California

  In its June 2006 analysis of Assembly Bill 2012 (AB 2012), the California Health Benefits Review Program (CHBRP) found that the cost of mandating orthotic and prosthetic coverage (the average portion paid by members through cost sharing, including the portion over any annual benefit limit) would be between $0.15 and $0.25 per member per month (PMPM). The increases in premiums would vary by market segment: $0.14 PMPM in the large-group HMO and PPO/FFS markets; $0.26 PMPM in the small-group HMO market; and $0.16 PMPM in the small group PPO/FFS market. It is important to note that, unlike the California legislation, House Bill 317 does not call for mandating coverage for orthotic devices.

  ACA also reported that CHBRP "found that AB 2012 would cause a decrease in the cost of the covered benefits paid by the member (deductibles, co-payments, etc.)," and that "the average portion of the premium paid by the employer would only increase by about $0.08 and $0.19 ($0.11 across all plans)." According to ACA, this eliminates the argument that House Bill 317 would prevent small businesses from providing insurance due to cost.

  However, in its analysis of Assembly Bill 2012, CHBRP concluded that while the legislation would not impact the state's medical costs or health insurance premiums, the bill also would <u>not</u> impact public health or health outcomes. Based on this conclusion about similar legislation not improving health outcomes, Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that there is no benefit to mandating such coverage, since BCNEPA estimates found that such a mandate could negatively impact Pennsylvania's health care costs [see section (VIII, A)].

  In its submission, Highmark cited CHBRP's earlier, April 2006 analysis of a prior version of AB 2012, which highlighted California's current utilization of orthotic and prosthetic devices. The total PMPM cost of orthotic (which are not included in House Bill 317) and prosthetic devices was determined to be $0.65, based on "Milliman national claims data which indicates a utilization rate of 40.4 procedures per 1,000 members and an average

allowed cost of $193 per procedure." CHBRP estimated that, on average, 82% of the costs are paid by the plan and 18% are paid by the member. (In the June analysis of AB 2012, CHBRP estimated the current PMPM cost of orthotic and prosthetic devices differently than in the April 2006 analysis. It determined a PMPM cost of $0.74, of which $0.16 was for prosthetic devices and $0.57 was for orthotic devices.)

Again, it should be noted that since the California law was passed in 2006, the above information was estimated prior to full implementation. No information regarding impact following full implementation was submitted.

- Colorado

According to ACA, the Colorado Department of Health Policy and Planning found the financial impact of its legislation to be an increase in premiums of approximately $0.12 PMPM. ACA also noted that, in the first year of implementation in Colorado, this state found that providing orthotic and prosthetic coverage for Medicaid recipients saved almost a half a million dollars, and that these savings were for medical expenses only. Colorado did not factor in additional savings from people returning to work, leaving the Medicaid rolls, or resuming their role as taxpayers.

- Massachusetts

In 2005, the Massachusetts Division of Health Care Finance and Policy estimated the cost for Massachusetts House Bill 376, which would mandate coverage for certain prosthetic devices. It developed the following low, mid and high-range estimates, which ACA's submission reported as:

Summary of Cost Impact Scenarios for Prosthesis Mandate

	2006	2007	2008	2009	2009	5-Year
Low Scenario						
Monthly Premium Impact	$ 0 .27	$ 0 .27	$ 0 .28	$ 0 .29	$ 0 .30	$ 0.28
Mid-Range Scenario						
Monthly Premium Impact	$ 0 .34	$ 0 .35	$ 0 .42	$ 0 .35	$ 0 .35	$ 0.35
High Scenario						
Monthly Premium Impact	$ 0 .53	$ 0 .48	$ 0 .46	$ 0 .45	$ 0 .45	$ 0.48

The Insurance Federation of America stated that the Massachusetts report painted a frightening picture of costs that could arise. The reported noted:

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

- New Jersey

  New Jersey's Mandated Health Benefits Advisory Committee found that mandating coverage for prosthetic and orthotic devices would result in average premium increases of $0.025 per $1,000 of premium. At the high end, one plan in the study said that the cost of providing such coverage would be $0.080 per $1,000 of premium.

While it didn't cite the specific states nor provide specific data, ACA wrote that other states have found that reducing or eliminating prosthetic coverage has ended up costing them more money. ACA noted that both the California and Colorado reports referenced above mentioned that providing prosthetic services reduces the economic loss associated with the conditions that require the use of prostheses.

Finally, it should be reiterated that the bills in the aforementioned states may differ from House Bill 317. Additionally, copies of the actual studies conducted in these states were only received for New Jersey (submitted by Highmark and ACA) and California (Highmark submitted the earlier version of two analyses conducted). The findings from Colorado, Massachusetts and California's second analysis were summarized in the submissions, but the actual studies were not included.

C. The extent to which the proposed benefit would increase the appropriate use of treatment or service.

While Highmark reiterated that it already provides prosthetic coverage to its members, it noted that its experience "has found that whenever a service becomes eligible for insurance coverage, utilization of that service or benefit immediately increases." However, Highmark stated that since House Bill 317 would affect only a limited number of individuals, it expects the first persons to use this benefit would be those with limited or no coverage.

Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that although it is difficult to estimate House Bill 317's impact on utilization, the legislation would eliminate an insurer's ability to set appropriate annual benefit limits and that insurers would face reimbursement costs of as much as $70,000 for a single device. As mentioned in section (V), BCNEPA reported that the bill would eliminate an insurer's ability to use available medical studies to establish policies and would require insurers to provide for unlimited replacements of devices based solely on determinations by prescribing physicians.

The Amputee Coalition of America (ACA) stated that prostheses are currently out of reach for many amputees who lack proper coverage. However, as mentioned in section (I), ACA reported that this legislation will not increase utilization, just availability, unlike many other mandated benefits. Still, based on ACA's assertion that some amputees with ill-fitting, worn or inappropriate devices currently have to limit their use of prostheses, it can be assumed that legislation enabling more repairs and replacements would increase repairs and replacements.

D. The impact of the benefit on administrative expenses of health care insurers.

The Amputee Coalition of America (ACA) reported that insurers currently receive numerous appeals related to prosthetic care restrictions, and it asserted that prosthetic parity would

reduce such appeals and generate a cost savings in this area. No specific dollar figures were given to quantify the cost savings, nor was information on the number of appeals provided. ACA also noted that utilization review costs for insurers are not an issue for prosthetic care since Medicare has developed a rigorous utilization review system that is also used by physicians who prescribe care to privately insured amputees.

Highmark actuaries estimated that House Bill 317's impact on administrative expenses would be minimal due to the insurer's existing coverage.

E. The impact of the proposed benefits on benefits costs of purchasers.

The Pennsylvania Chamber of Business and Industry stated that employers in the Commonwealth already struggle to afford health coverage and any expansion of mandated benefits drives up health care costs. The Chamber cited a recent national survey that found that 15% of increases in U.S. heath care costs – or $10 billion – can be attributed to mandated benefits and regulation. It also raised concern about the cumulative impact of Pennsylvania's mandated benefits:

> While one individual mandate, such as that proposed by House Bill 317, may have minimal impact on costs, the cumulative impact of 30 or more mandates has a substantial impact on the affordability of health insurance coverage and imposes additional financial burdens [on] the payers of health insurance, whether they be private or public. These burdens would be imposed on the very businesses that are providing good family-sustaining jobs, pay good wages, and offer health care benefits.

According to the Chamber, studies show that, in addition to increasing premium costs, each new mandated benefit increases by 1.5% the likelihood that a small employer may not be able to offer health coverage. Furthermore, it stated that mandates make it harder for Pennsylvania to attract, expand and retain businesses.

The Insurance Federation of Pennsylvania echoed the Chamber's concerns about the costs of mandated benefits falling disproportionately on small employers. The Federation added, "Since these benefits cannot be provided to employees free, either the compensation of existing employees or new job formation must be negatively affected."

Independence Blue Cross (IBC) also noted the effect of mandates on the number of uninsured. IBC cited a 1999 Health Insurance Association of America study [also referenced in section (III)] that found that as many as one in four people are uninsured because of the cost of state health insurance mandates. For every one percent increase in health care costs, another 14,000 Pennsylvanians will lose health care coverage.

As previously noted in section (III), Capital BlueCross and Highmark both indicated that the mandate would limit the ability of purchasers to select benefit packages that best meet their needs. Capital BlueCross indicated that it provides a limited number of products that exclude prosthetics coverage so that basic coverage can be provided to low-income customers for an affordable price. It is concerned that House Bill 317 would make health insurance less affordable for those opting to purchase one of these products. Highmark also stated that while most of its health benefit plans offer standard prosthetic coverage, it makes sense to be able to offer such coverage as an optional benefit in some instances.

However, as with the impact of the proposed benefit on insurers' administrative expenses, Highmark actuaries projected that the impact of House Bill 317 alone on purchasers' benefits costs would be minimal. Nevertheless, Highmark also pointed out the cumulative impact of mandated benefits as a cost driver of health insurance premiums. As part of its submission, Highmark included a copy of the Council for Affordable Health Insurance's *Health Insurance Mandates in the States: 2007*, which found that Pennsylvania has 31 health insurance mandates – including 17 mandated benefits and 14 mandated providers.)

As mentioned in section (VIII, A), Blue Cross of Northeastern Pennsylvania (BCNEPA) estimated that the legislation would increase the annual cost of an individual prosthetic claim from $486 to $972. Since the legislation does not allow insurers to adopt caps or other limitations, BCNEPA also stated that the costs borne by purchasers are likely to increase as technology advances. BCNEPA repeated the same concerns as other opponents related to the negative impact on small and medium-sized businesses and on individuals who are not able to absorb annual cost increases or self-insure.

The Amputee Coalition of America (ACA) noted that prosthetic coverage for the privately insured population is associated with a low cost per member per month. As mentioned in section (VIII, B), ACA also reported that California found that its proposed legislation "would cause a decrease in the cost of the covered benefits paid by the member (deductibles, co-payments, etc.)" and that "the average portion of the premium paid by the employer would only increase by about $0.08 and $0.19 ($0.11 across all plans)." According to ACA, this eliminates the argument that House Bill 317 would prevent small businesses from providing insurance due to cost. ACA added that other states that have passed prosthetic parity legislation have not reported any increase in the number of uninsured due to the legislation. Yet, it is important to point out that since over half of the states with prosthetic parity passed the legislation within the past two years, it may be too soon to gauge the impact on the uninsured rate.

F. The impact of the proposed benefits on the total cost of health care within the Commonwealth.

PHC4's estimate of the impact of House Bill 317 is based on several points previously raised, as well as hospital admissions data that hospitals are required to send to the Council on a quarterly basis. It should be noted that while the legislation calls for coverage of fittings, repairs and replacements of prosthetic devices and/or components, the Council was unable to estimate projected costs for fittings and repairs as no documentation was submitted from proponents or opponents on these costs nor does PHC4 collect this data from providers. Therefore, projected costs were calculated only for 1) the actual prosthetic devices in a "start-up" year and 2) replacing devices every five years.

Cost of prosthetic devices. As noted earlier in sections (I), the costs of prosthetic devices vary by body part and technological advancement. To calculate costs for initial and replacement devices, PHC4 developed three scenarios based on low, mid-range and high price estimates. PHC4 used the breakdown that was developed by the California-based Amputee Services and Technical Assistance Program and submitted by the Amputee Coalition of America:

Lower-extremity devices

- $5,000 to $7,000 for a below-the-knee prosthesis that enables standing and walking on level ground
- $10,000 for a below-the-knee prosthesis that enables traveling up and down stairs and walking on uneven ground
- $12,000 to $15,000 for a prosthetic leg that enables running and functioning almost on par with someone with two legs
- $15,000 or more for devices with polycentric mechanical knees, swing-phase control, stance control, and other mechanical or hydraulic systems
- $20,000 to $30,000 starting prices for computer-assisted devices

Upper-extremity devices

- $3,000 to $5,000 for a nonfunctional cosmetic hand
- $10,000 for transradial prosthesis, which is a "split hook" below-the-elbow device
- $20,000 to $30,000 for realistic myoelectric hands that open and close

Population affected. Two affected populations were identified – one that would take advantage of the benefit in a "start-up" year and one that would take advantage of its replacement provision.

Cost estimates for devices in the "start-up" year calculation (see Table 1) were based on discharge data submitted to PHC4 by Pennsylvania hospitals. It should be noted that the number of lower and upper-extremity amputations performed annually in Pennsylvania hospitals has been very consistent over the past five years. In 2006, 3,361 Pennsylvania residents underwent lower-extremity amputation procedures (excluding toes); 76 underwent upper-extremity amputations (excluding fingers). Since House Bill 317 only applies to commercially insured patients, it was estimated that 777 prosthetic devices would be covered. The calculation for the annual cost of replacement devices (see Table 2) assumed that each of the 37,014 amputees in the state covered by commercial insurance, previously reported in section (I), would obtain one replacement every five years.

For both populations, PHC4 estimated that 46% of the commercially insured patients were in self-insured (ERISA-exempt) health plans not eligible for mandated benefits. This estimate was based on figures presented by M. Diane Koken, former Commissioner of the Pennsylvania Insurance Department, in testimony to the House of Representatives on April 5, 2005. It was also assumed that a large number of the patients affected by the mandate would take advantage of its benefits. While no specific information was supplied that would help in determining a utilization figure, a 75% utilization rate was assumed. For the annual replacement figures, it was assumed that devices would be replaced every five years, since they are typically designed to last three to five years as mentioned in section (II).

Table 1. "Start-up" Year Costs – Low, Mid-Range & High Price Estimates

	Totals	Below Knee	Above Knee	Hand/Wrist/ Forearm
Prostheses for commercially insured	777			
Less self-insured plans	357			
Less above-the-elbow amputees[1]	9			
Prostheses given 75% utilization[2]	308	241	59	8
Low cost estimate per device		$5,000	$12,000	$3,000
Total low cost estimate	$1,937,000	$1,205,000	$708,000	$24,000
Mid-range cost estimate per device		$10,000	$15,000	$10,000
Total mid-range cost estimate	$3,375,000	$2,410,000	$885,000	$80,000
High cost estimate per device		$20,000	$20,000	$20,000
Total high cost estimate	$6,160,000	$4,820,000	$1,180,000	$160,000

[1]Amputees with above-the-elbow/humerus/shoulder amputations were excluded because price estimates for correlating prosthetic devices were not available.
[2]Estimates of the number of prosthetic devices needed for this population were formulated using the number and type of amputation procedures performed.

Table 2. Annual Replacement Costs – Low, Mid-Range & High Price Estimates

	Totals	Below Knee	Above Knee	Hand/Wrist/ Forearm
Prostheses for commercially insured	37,014			
Less self-insured plans	17,026			
Less above-the-elbow amputees[1]	200			
Prostheses given 75% utilization	14,841			
Prostheses replaced each year[2]	2,968	1,910	1,028	30
Low cost estimate per device		$5,000	$12,000	$3,000
Total low cost estimate	$21,976,000	$9,550,000	$12,336,000	$90,000
Mid-range cost estimate per device		$10,000	$15,000	$10,000
Total mid-range cost estimate	$34,820,000	$19,100,000	$15,420,000	$300,000
High cost estimate per device		$20,000	$20,000	$20,000
Total high cost estimate	$59,360,000	$38,200,000	$20,560,000	$600,000

[1]Amputees with above-the-elbow/humerus/shoulder amputations were excluded because price estimates for correlating prosthetic devices were not available.
[2]Estimates for the distribution across types of devices were developed using patterns apparent in PHC4's data. It was assumed a prosthetic device would be replaced every five years, since devices are typically designed to last three to five years.

Submissions for House Bill 317

1. AFLAC – The American Family Life Assurance Company of Columbus

    - Statement addressing certain Section 9 requirements.

2. American Orthotic & Prosthetic Association

    - Letter and comments in support of House Bill 317.

3. Amputee Coalition of America

    - Letter and comments in support of House Bill 317.
    - Statement addressing Section 9 requirements.
    - Attachments addressing limb loss, the economic and social benefits of prosthetic coverage, current coverage restrictions and mandated benefits.
    - News articles and letters to the editor in support of House Bill 317.
    - Letters from other advocates in support of House Bill 317.

4. Amputee Support Group at Health South Rehab (Harmarville, PA)

    - Letter in support of House Bill 317.

5. Benchmark Medical, Inc.

    - Letter and comments in support of House Bill 317.

6. Blue Cross of Northeastern Pennsylvania

    - Statement addressing Section 9 requirements.

7. Patrick T. Bolden, M.D.

    - Letter in support of House Bill 317.

8. Capital BlueCross

    - Letter and comments in opposition to House Bill 317.

9. Georgia Foltz

    - Letter and comments in support of House Bill 317.

10. Highmark

    - Statement addressing Section 9 requirements.
    - Attachments addressing limb loss, prosthetic devices and mandated benefits.

11. Donald E. Hossler

    - Letter with attached documentation in support of House Bill 317.

12. Independence Blue Cross

    - Letter in opposition to legislated mandates.

13. The Insurance Federation of Pennsylvania

    - Statement addressing Section 9 requirements and opposing House Bill 317.
    - News article which discusses the issue of parity (referenced in above statement).

14. Harry J. Lawall & Son, Inc.

    - Letter in support of House Bill 317.

15. D.A. Mantini Artificial Limb & Brace Company

    - Letter in support of House Bill 317.

16. Pennsylvania Chamber of Business and Industry

    - Letter and comments in opposition to mandated benefits.

17. Pennsylvania Council on Independent Living

    - Letter and comments in support of House Bill 317.
    - Attachments on the economic and social benefits of prosthetic coverage.

18. Pennsylvania Orthotic and Prosthetic Society

    - Letter in support of House Bill 317.

41 constituent letters in support of House Bill 317