November 16, 2023

Ashley Setala
Minnesota Department of Commerce
Insurance Division
85 7th Place East, Suite 280
St. Paul, MN 55101

RE: Response to Request for Information Mandated Health Benefit Proposal Evaluations dated 10/4/2023 from MN Department of Commerce concerning HF 3339 / SF 3351: A bill for an act relating to insurance; requiring coverage for orthotic and prosthetic devices; authorizing rulemaking; proposing coding for new law in Minnesota Statutes, chapter 62Q.

Dear Ashley Setala & MN Department of Commerce,

On behalf of the Minnesota Society of Orthotists, Prosthetists & Pedorthists (MSOPP), the intention of this letter is to respond to the Request For Information (RFI) concerning Minnesota HF 3339 / SF 3351. Thank you for the opportunity to do so.

MSOPP is a non-profit organization with members who are predominantly MN-licensed/certified prosthetists, orthotists, pedorthists, and assistants, along with residents, technicians and administrators who all work in the orthotic and prosthetic profession. Our mission is to protect the public health and promote the welfare of residents of the State of Minnesota who have physical disabilities by maintaining and elevating the standards, education and ethical conduct of Orthotists, Prosthetists and Pedorthists as professionals. For more than a dozen years, MSOPP has continued to foster communication regarding proposed legislative efforts that have a positive impact on residents of Minnesota needing orthotic, prosthetic and pedorthic services.

The proposed legislation HF 3339 / SF 3351creates coverage for Minnesotans in need of orthotic and prosthetic (O&P) care and devices:
1) at a level that is equivalent to the federal Medicare program;
2) for purposes of performing physical activities;
3) for purposes of showering or bathing; and
4) that follows nondiscrimination standards in the provision of care.

Proposed Mandate Summary: This proposed mandate would require a health carrier to provide health insurance coverage for orthotic and prosthetic devices, supplies, and services. Medical necessity must be determined by a prescribing physician or licensed health care provider with the appropriate scope of practice in Minnesota for coverage. A health plan must cover orthoses and prostheses which are determined by the physician or provider to be the most appropriate model that meets the medical needs of the enrollee. Prior authorization may be required by a health plan for orthotic and prosthetic devices, supplies, and services in the same manner and to the same extent as required for any other covered benefit.

Following the recommendation for this RFI issued by MN Commerce, we have provided our responses in question-and-answer format below.

1. As it is written now, does this proposed health benefit mandate achieve its intended purpose as described in the RFI?
    a. As currently written HF 3339 / SF 3351 achieves its intended purpose for private plans, however, the legislation will be amended to include coverage under state plans such as Minnesota Medicaid and MNCare (as originally intended).
    b. As currently written, it will address this policy challenge by ensuring that state-regulated health insurance policies provide coverage and reimbursement for prescribed orthotics and prosthetics at the same level as Medicare.
    c. It will also address the fact that today, 28,000 Minnesotans with limb loss and thousands more with limb difference and mobility impairments are unable to access prescribed, life-changing O&P care due to a lack of coverage and affordability in state and private health plans. This is especially true for prostheses and orthoses utilized for physical activity or showering/bathing, which are often deemed "not medically necessary." Without appropriate health coverage, adults, children, and families are forced to incur prohibitive out-of-pocket costs, risk harm or injury using an inappropriate device, or live sedentary lifestyles with costly secondary health complications.
    d. In addition, nondiscrimination standards outlined in HF 3339 / SF 3351 will guarantee that Minnesotans living with limb loss, limb difference, and mobility impairment will receive the same standard of care as patients without a disability.

2. Are all services or items that should be covered in this proposed health benefit mandate included? If not, what other items or services should be considered?
    a. To the extent known, all applicable O&P care and devices prescribed/ordered by MN prescribers are included in the bill language.
    b. Specifically, O&P services/items are proposed to be covered:
        1) at a level that is equivalent to the federal Medicare program;
        2) for purposes of performing physical activities;
        3) for purposes of showering or bathing; and
        4) that follows nondiscrimination standards in the provision of O&P care.

3. If the proposed health benefit mandate were signed into law, how would it impact individuals' access to health care? In your response, please consider access under current coverage requirements, whether additional steps are required to access care (e.g., the need for prior authorization for a service or item), and if the change in coverage associated with the proposed mandate would impact certain populations more than others.
    a. If signed into law, the mandate requiring coverage to be on par with Medicare would greatly benefit Minnesotans' access to health care, specifically with regard to prescribed O&P care and devices.
    b. If signed into law, the mandate will positively impact disabled children and adults who rely on O&P devices to improve function and mobility to safely live more healthy and active lives. It will ensure individuals with disabilities can access activity-specific O&P devices to reap the benefits of physical activity in the same manner as their non-disabled Minnesotan peers.
    c. If signed into law, the mandate would change the current Minnesota state and private health plans' more restrictive views that only one prosthesis or orthosis is

covered to ambulate or walk. More than one orthosis or prosthesis is needed to perform Activities of Daily Living, including exercise, recreation, showering and bathing. Multiple devices are often necessary to restore full human function; this is already the standard of care being provided by the Veterans Affairs (VA) and Department of Defense (DoD) to active-duty military and retired veterans living with limb loss, limb difference, and mobility impairment.

d. Proposed coverage would likely follow current requirements of private and state protocols for prior authorization / utilization review of prescribed O&P devices.

4. Are there any currently established health care policies related to this proposed health benefit mandate that Commerce should consider during their evaluation?
    a. The Affordable Care Act includes orthotic and prosthetic devices as essential health benefits ("EHB"). Activity-specific prostheses and custom orthoses are, in fact, already included in the Affordable Care Act's "EHB" package for rehabilitation and habilitation services and devices covering medically necessary O&P care.
    b. HF 3339 / SF 3351 will ensure Minnesotans with disabilities can access activity-specific prostheses and orthoses to reap the benefits of physical activity and personal hygiene in the same manner as their non-disabled Minnesotan peers.

5. Based on the Data Availability and Sources (Appendix A) outlined in the RFI, are there other resources or considerations Commerce should assess during their evaluation of the proposed health benefit mandate (e.g., journal articles, databases, etc.)?
    a. Please see social and fiscal impact study from Colorado ensuring coverage of activity-specific O&P care imposes little cost to insurance companies: a study of two bills enacted into law in Colorado and Illinois found their projected costs to be $0.01-$0.08 and $0.01-$0.33 per member per month (PMPM), respectively, less than 0.003% of the annual amount spent on healthcare per capita in the United States ($10,000). In fact, the study suggests that activity-specific coverage may present significant long-term savings, as patients are able to reduce the costly consequences of sedentary living and reap the health outcomes physical activity provides.[1] ***A Multi-State Analysis of the Fiscal and Social Impact of Commercial Insurance Coverage for Recreational Prostheses in the United States*** Shaneis Kehoe CO, MS, Jeffrey Cain MD, Angela Montgomery CPO, Lindi Mitsou CPO, MSPO, 2023
    b. For a similar social and fiscal impact study from Maine, please see: ***A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature Review and Evaluation of LD 1003 An Act to Improve Outcomes for Persons with Limb Loss*** February 2022 Prepared by: Donna Novak, FCA, ASA, MAAA Al Bingham, FSA, MAAA of NovaRest, Inc. Marti Hooper, ASA, MAAA of the Maine Bureau of Insurance [2]

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[1] Kehoe, Shaneis et al. *A Multi-State Analysis of the Fiscal and Social Impact of Commercial Insurance Coverage for Recreational Prostheses in the United States*. Medical Research Archives, [S.l.], v. 11, n. 5, may 2023. ISSN 2375-1924. https://esmed.org/MRA/mra/article/view/3809

[2] Novak, Donna et al. ***A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature Review and Evaluation of LD 1003 An Act to Improve Outcomes for Persons with Limb Loss*** February 2022 https://www.maine.gov/pfr/sites/maine.gov.pfr/files/inline-files/LD1003-Maine-Mandated-Benefit-Athletic-Prosthetic-Report.pdf

6. Would you expect there to be a difference in cost of services or items covered under the proposed health benefit mandate for patients, providers, and/or Payers/issuers?
    a. O&P devices are predominantly described/billed/found on the HCPCS coding system and reimbursed accordingly. Codes for O&P devices included in this mandate will use the same codes and coding system, and most will fit within current classes of existing codes.

7. In your 6 responses, please consider any impacts on health outcomes, such as the impact of increased coverage resulting in reduced hospitalizations.
    a. The positive impacts on health outcomes and reduced hospitalizations are exponential as those living more active lifestyles are less likely to be impacted by the negative effects of living a sedentary lifestyle.
    b. Movement is medicine. Physical inactivity increases the risk of heart disease, stroke, type 2 diabetes, and a number of cancers.[3] On top of this, obesity, chronic loneliness, and isolation are some of the fastest-growing public health problems in the U.S. today, and people with disabilities are disproportionately at risk.[4] Adults and children with mobility limitations are unfortunately at greatest risk for obesity.[5] Despite the U.S. Department of Health and Human Services' (HHS) Physical Activity Guidelines – which recommends children with disabilities get 60 or more minutes each day of moderate or vigorous intensity aerobic physical activity, and adults, 150 minutes weekly[6] – 50% of adults with disabilities get absolutely no aerobic physical activity[7] and children with disabilities are 4.5 times less likely to engage in physical activity than children without disabilities – 50% of adults with disabilities get absolutely no aerobic physical activity[8] and children with disabilities are 4.5 times less likely to engage in physical activity than children without disabilities[9]. According to the 2022 U.S. Report Card on Physical Activity for Children and Youth, the U.S. received an "F" grade for children with disabilities, with less than 17.5% meeting the recommended daily physical activity.[10] Without equitable access to appropriately designed prosthetic and orthotic devices, trying to meet the HHS Physical Activity Guidelines is not only impossible, but it is dangerous and harmful when utilizing the wrong device. Activity-specific O&P devices are required for individuals with either upper or

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[3] Centers for Disease Control and Prevention (2014). *Facts about Physical Activity*: https://www.cdc.gov/physicalactivity/data/facts.htm

[4] U.S. Department of Health and Human Services, *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community*: https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

[5] Centers for Disease Control and Prevention (CDC), *Disability and Obesity*: https://www.cdc.gov/ncbddd/disabilityandhealth/obesity.html

[6] U.S. Department of Health and Human Services, *Physical Activity Guidelines for Americans, 2nd Edition*: https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf

[7] Centers for Disease Control and Prevention (CDC), *Inactivity Related to Chronic Disease in Adults with Disabilities*: https://www.cdc.gov/nccdphp/dnpao/division-information/media-tools/dpk/vs-disability-activity/index.html#:~:text=Working%20age%20adults%20with%20disabilities,for%20Disease%20Control%20and%20Prevention.

[8] Centers for Disease Control and Prevention (CDC), *Inactivity Related to Chronic Disease in Adults with Disabilities*: https://www.cdc.gov/nccdphp/dnpao/division-information/media-tools/dpk/vs-disability-activity/index.html#:~:text=Working%20age%20adults%20with%20disabilities,for%20Disease%20Control%20and%20Prevention.

[9] American College of Sports Medicine, *Why We Must Prioritize Equitable Access to Physical Activity for Children with Disabilities*: https://www.acsm.org/blog-detail/acsm-blog/2021/03/22/prioritize-equitable-access-to-physical-activity-for-children-with-disabilities

[10] Physical Activity Alliance, *The 2022 United States Report Card on Physical Activity for Children and Youth*: https://paamovewithus.org/news/2022-u-s-report-on-physical-activity-for-children-and-youth/

lower limb loss and limb difference to participate in physical activities such as running, biking, swimming, rock climbing, skiing, snowboarding, and more.

c. The consequences of a sedentary lifestyle are not confined to negative health outcomes at the individual level: a lack of physical activity also causes a severe, systemic strain on the nation's healthcare economy. A 2014 study published in Progress in Cardiovascular Diseases estimates that spending related to physical inactivity represents 8.7% of US healthcare expenditures, or roughly $117 billion, per year.[11]
d. The positive impacts on health outcomes from this proposed legislation can also be expected in cost savings for unemployment insurance, state employment and training programs, rehabilitation and counseling programs, and other social welfare systems when Minnesotans are provided the O&P devices that enable them to lead more healthy, independent lives.

RFI Mandate-Specific Questions: In addition to the general questions above, Commerce also seeks feedback on the following mandate-specific questions:

1. What are the current challenges for access to orthotic and prosthetic devices and associated supplies or services (repair, evaluation, etc.)?
    a. Coverage for O&P care and devices in MN is currently not on par with Medicare (or the Veteran's Administration), therefore access to care and devices is limited for the disabled individuals in need. Providing quality O&P care that is on-par with Medicare leads to better quality-of-life for patients with little additional cost. A 2018 study published in the Journal of NeuroEngineering and Rehabilitation found that "patients who received lower-extremity prostheses had comparable Medicare episode payments (including the cost of the prosthesis) and better outcomes than patients who did not receive prostheses."[12]
    b. In MN, access to O&P care and devices for activity/recreation and bathing/showering through private or state insurance coverage is currently not available. The Affordable Care Act includes O&P devices as essential health benefits (EHB); however, challenges for access to EHB exist in MN for those in the disabled community who rely on them for their activities of daily living, which include exercise and bathing.
    c. In addition, putting more strain on a prosthetic or orthotic device not appropriately designed for physical activity may also result in damage to the device, resulting in more expense for insurance providers.[13]
    d. Nondiscrimination standards outlined in HF 3339 / SF 3351 will guarantee that Minnesotans living with limb loss, limb difference, and mobility impairment will have access to the same standard of care as patients without a disability. Orthotic and prosthetic services are often directly comparable to surgeries and procedures that enable mobility or athletic performance. For example, ACL surgery, while

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[11] Carlson SA, Fulton JE, Pratt M, Yang Z, Adams EK. Inadequate Physical Activity and Health Care Expenditures in the United States. Progress in cardiovascular diseases. 2015;57(4):315-323. 2014.08.002. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4604440/

[12] Dobson A, Murray K, Manolov N, DaVanzo JE. Economic value of orthotic and prosthetic services among medicare beneficiaries: a claims-based retrospective cohort study, 2011-2014. J Neuroeng Rehabil. 2018 Sep 5;15(Suppl 1):55. https://jneuroengrehab.biomedcentral.com/articles/10.1186/s12984-018-0406-7

[13] Maine Bureau of Insurance, *Review and Evaluation of LD 1003 An Act to Improve Outcomes for Persons with Limb Loss*: https://www.maine.gov/pfr/sites/maine.gov.pfr/files/inline-files/LD1003-Maine-Mandated-Benefit-Athletic-Prosthetic-Report.pdf

considered an elective procedure, is typically covered because the treatment is necessary to restore the body to its full potential, mobility and athletic performance. Between 100,000 and 300,000 ACL-related procedures take place in the U.S. each year,[14] yet comparable care for patients in need of O&P services that also restore the body to its full potential, mobility and athletic performance are not covered.

e. Nondiscrimination standards outlined in HF 3339 / SF 3351 will guarantee that Minnesotans living with limb loss, limb difference, and mobility impairment will have access to the same standard of care as patients without a disability. For example, knee and hip replacements, also known as "internal prostheses", are also routinely covered to eliminate pain, correct deformity, and improve mobility. About 700,000 knee replacements and about 400,000 hip replacements are performed in the U.S. each year.[15] However, coverage of "external prostheses" such as microprocessor controlled prosthetic knees (MPKs), that restore the same function, are often denied for people with disabilities. HF 3339 / SF 3351 will ensure state and private health plans will not be able to deny a prescribed prosthetic or orthotic device benefit for an individual with limb loss or limb difference that would otherwise be covered for a person without a disability seeking medical or surgical intervention to restore or maintain the ability to perform the same function.

2. Do the coverage requirements of the bill adequately address needs of the pediatric population?
    a. The coverage requirements of this bill will help address and improve the O&P needs of Minnesota's pediatric population and will help this population live more safe, healthy and active lives. Activity-specific custom orthoses and prostheses are necessary to allow a child or adult to engage in exercise and recreation, and showering and bathing devices are necessary to allow them to safely maintain hygiene associated with activities of daily living. If enacted, this proposed legislation will empower all Minnesotans with mobility impairments to access the physical, mental, and social health benefits provided by physical activity and self-care.

3. Are there current differences between medical necessity determinations made by issuers in utilization management (prior authorization) and those supported by current clinical practice guidelines?
    a. Yes, in MN there are differences in interpretations by those reviewing medical necessity documentation through the processes of prior authorization and utilization review. Current clinical practice guidelines are interpreted more critically by some private plans than others and the differences give rise to discriminatory practices in the provision of O&P care for this disabled population in Minnesota.

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[14] Macaulay, Alec A et al. "Anterior cruciate ligament graft choices." Sports Health vol. 4,1 (2012): 63-8. doi:10.1177/1941738111409890 https://www.researchgate.net/publication/231215771_Anterior_Cruciate_Ligament_Graft_Choices

[15] Mayo Clinic, *Mayo Clinic Q and A: When your hip and knee both need to be replaced*: https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-q-and-a-when-your-hip-and-knee-both-need-to-be-replaced/

b. Please see attached matrix entitled “A Comparison of Variable O&P Coverages Across Plans that Affect Minnesotans.”

On behalf of MSOPP and the population of Minnesotans we are privileged to serve, those living with limb loss, limb difference and mobility impairments that require the use of O&P devices for mobility and activities of daily living, we thank you for your review of this information. Please communicate should you have questions or need anything further. We can be reached by phone (763)744-8731or email at teri@arise-op.com.

Kindest regards,

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Roger Wagner, CPO/LPO, MSOPP Vice President, Century College
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