

A Multi-State Analysis of the Fiscal Impact of Commercial Insurance Coverage for General-Use & Activity-Specific Prosthetic & Orthotic Devices in the United States

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Abstract:

Prosthetic and orthotic devices are assistive devices utilized by individuals with limb loss, limb difference, and mobility impairment. Research has shown these devices improve mobility and functionality, independence, and overall quality of life for individuals with disabilities who depend on them [1]. This report focuses on two use types of prosthetic and orthotic devices: general-use and activity-specific. General-use prostheses and orthoses are designed to achieve the basic needs of ambulation and upper-limb functionality. In contrast, activity-specific devices are designed to support higher-intensity physical activities and recreation.

Currently, 29 states do not require insurance coverage for general-use prosthetic and orthotic devices, and 45 states do not require insurance coverage for activity-specific devices, hindering individuals with limb loss, limb difference, and mobility impairment from essential life

functions, including regular exercise required to prevent chronic illnesses [2].

This study analyzes proposed legislation in 11 states, aiming to expand state-regulated coverage for prosthetic and orthotic devices for the purpose of improving quality of life and longevity of health, including chronic illness prevention. The methodology includes estimating the per member per month (PMPM) and net cost variations per state based on U.S. Census populations, Center of Medicare and Medicaid Services (CMS) Public Use Data Files and state-specific Medicaid fee schedules. The authors hypothesize that expanded insurance coverage could yield long-term social and fiscal benefits to the patient and healthcare systems.

Results show PMPM estimates for states pursuing various levels of coverage, encompassing both general-use and activity-specific devices. The analysis conservatively estimates small PMPM increases based on assumptions related to device coverage costs and utilization. The results further emphasize potential overall healthcare savings from insurance coverage for these devices with the implementation of the 11 legislative initiatives, from improved health outcomes, with minimal fiscal impact.

In conclusion, the net fiscal and social benefit of these states' proposed legislation is expected to outweigh the associated costs. The fiscal impact on total healthcare costs is relatively small compared to the potential positive benefits for patients and healthcare systems.

Introduction

According to the Kaiser Family Foundation, the United States (U.S.) leads global healthcare spending, investing around \$12.9K per capita annually. This statistic highlights healthcare

spending exceeds the gross domestic product (GDP) growth and total healthcare costs now account for more than 17 percent of GDP [3]. Despite this substantial investment, the U.S. has the lowest life expectancy among industrialized nations. Additionally, the country has seen a concerning decline in life expectancy for the second consecutive year, with a reduction of 2.7 years since 2020—the first decline since 1923 [4]. The primary cause of death in the United States is heart disease, often linked to chronic conditions like unhealthy blood cholesterol levels, diabetes mellitus, and obesity. According to the Centers for Disease Control (CDC), these diseases are preventable through exercise and a healthy diet [5].

The gap between significant healthcare spending and decreasing life expectancy indicates a need to reassess the current insurance coverage landscape, especially concerning preventative health services. Exploring the inclusion of preventive measures within insurance coverage could address this disparity, offering potential improvements in both short- and long-term physical and behavioral health outcomes and broader healthcare systematic impacts. Thus, understanding opportunities for populations at risk for the leading cause of death to exercise regularly is the hypothesized approach to decreasing healthcare costs and improving life expectancy.

Currently, 29 states in the U.S. do not require coverage of general-use prosthetic and orthotic devices, and 45 states do not require coverage of activity-specific devices [6]. Thus, the lack of coverage creates a health access barrier and health equity concern for those experiencing limb loss, limb difference, or mobility impairment.

This study analyzes potential coverage for two types of device use. First, general-use devices are defined as prosthetic and orthotic devices

designed to achieve the basic needs of ambulation and upper-limb functionality. Second, activity-specific devices are defined as prosthetic and orthotic devices designed to support higher-intensity physical activities and recreation. Without these devices, individuals living with limb loss, limb difference, or mobility impairment are highly restricted in their ability to perform essential life functions, including exercise, to prevent chronic illness and heart disease [7][8].

To expand on the correlation between the cost of healthcare and this population, a recent study found the average cost per hospital stay accumulated to \$11,700, making hospitalization one of the most expensive categories of healthcare costs [9]. When considering the average cost of an amputation (a subcategory of hospitalization costs), a recent study focused on patient cost per amputation found that the overall per-patient cost for amputation was U.S. \$89,808 [10]. Therefore, the cost of amputation can be presumed to be one of the most expensive types of healthcare utilization and should be addressed accordingly. A solution could be hypothesized as providing insurance coverage for preventative health measures to decrease the prevalence of amputation and subsequent related costs.

Recent studies analyzed activity-specific prostheses' social and fiscal impact in Maine, Colorado, Connecticut, and Illinois. The results showed minimal per member per month (PMPM) estimates per state. As a result, 100% of legislation introduced referencing this data was enacted [11]. However, these studies only analyzed activity-specific prosthetic coverage and did not assess the general-use device cost or orthotic coverage component [12].

Additional research has shown considerable cost and patient outcome benefits from prosthetic and orthotic device use.

For every dollar spent on rehabilitation, there is a savings of more than \$11 in disability benefits. In addition, knee or hip problems resulting from lack of appropriate prosthetic care can result in health care costs ranging from \$80,000 to \$150,000 over a lifetime. Putting more strain on a daily prosthetic may result in damage to the prosthetic device, resulting in more expense for insurance providers. In addition, this treatment may lower the costs of mental health related issues and treatment. Children who are unable to participate in social or leisure activities with their peers due to a lack of appropriate prosthetics might see a negative impact on their quality of life and may develop mental health issues as a result. [13]

Considering the above findings, it is hypothesized that expanded state-regulated commercial insurance coverage of both general-use and activity-specific devices could generate long-term social and fiscal benefits by improving access to healthcare and enhancing patient outcomes compared to the current state insurance coverage options and standard of care.

This study aims to expand on previous relevant methodology previously used to calculate PMPM for activity-specific prosthetic device coverage. However, this analysis will seek to include general-use device insurance coverage of orthoses and prostheses and activity-specific device coverage in 11 states with proposed legislation. The outcome will calculate an estimated PMPM per state, estimated healthcare cost savings by providing preventative-related health benefits based on existing actuarial and policy review literature, and both values' overall net benefit or cost.

Methodology

Understanding the legislative landscape:

States proposing legislation on relevant device coverage in upcoming legislative sessions include Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, Ohio, Oregon, Pennsylvania, and Tennessee.

Among these, Idaho, Kentucky, Minnesota, Ohio, and Pennsylvania and Tennessee advocate for legislation to mandate commercial insurance for general-use and activity-specific prosthetic and orthotic device coverage.

States with previously enacted legislation covering general-use devices and seeking expanded coverage for activity-specific prosthetic and orthotic devices include Maryland, Massachusetts, New Hampshire, New Jersey, and Oregon.

Device type and coverage requirements for each state's legislation vary based on locally sponsored legislative representation and advocates' determination, which may change throughout upcoming legislative sessions. Thus, for the purpose of this study, estimates will be based on proposed levels of coverage as of the current date, January 2024 [6].

Understanding existing policy and research literature:

The existing literature used to calculate the estimated PMPM for activity-specific prostheses was analyzed using Minnesota's actuarial PMPM published by the Minnesota Department of Commerce [14]. Minnesota's actuarial analysis found minimal fiscal impact with a net increase of \$0.39 PMPM, with indications of improving

quality of life and decreasing the cost of episodic care.

Utilizing the \$0.39 PMPM estimate as a base value, various calculations can be applied to reach a similar estimate for the 11 additional states seeking legislation.

The first calculation aimed to understand the total cost breakdown between orthotic and prosthetic devices. Minnesota notes a total estimated paid expenditure amount of \$116,395,832 in the first year of the coverage across 84,776 orthoses (44.74% of total devices) and 21,520 prostheses (55.26% of total devices).

Suppose these percentages of costs are applied to the two categories of devices; a per-device PMPM can be calculated (image 1). This value is useful to apply on a population basis as each state's population varies, and the PMPM would change as a result. Population data referenced in this methodology comes directly from the U.S. Census Bureau's July 2022 report [15].

To further calculate the estimated cost within a state, the device utilization prevalence was calculated from Minnesota's analysis by comparing the 84,776 orthoses and 21,520 prostheses against their total population. As Minnesota's values and estimates projected in 2025, this study first recalculated the prevalence based on 2022 U.S. census values as the most recent published census data [16].

Orthoses were found to have a 1.47% prevalence, and prostheses were found to have a 0.37% prevalence against the total M.N. population. These prevalence values were used to calculate each additional state's device utilization values. Once device values were identified, the cost per device determined in image one was multiplied to individually estimate the PMPM associated with orthotic and

prosthetic coverage. Breaking out these two cost categories is imperative as states' coverages vary, and the related costs must be accounted for as such.

For example, Idaho is seeking legislation for orthotics and prosthetics for general and activity-specific use. Thus, the orthotic PMPM must be added to the prosthetic PMPM to sum up the general-use of PMPM. To ensure the activity-specific prosthetic PMPM value is then added, we assume an additional 50% of the prosthetic cost as a recent fiscal analysis estimates 50% utilization for activity-specific devices in comparison to general use devices [17].

In contrast, other states already have enacted insurance mandates covering general-use devices. Thus, only the activity-specific costs are summated to estimate the net PMPM. All calculations can be referenced in image 2.

Each state's employer-insured and nongroup member rate was gathered from the Kaiser Family Foundation's insurance coverage 2022 analysis to compare population variations in employer and nongroup insurance from Maine's member rate [18]. If the percentage of this covered population was lower than Maine's, the difference was flagged as a potential increase to the PMPM, based on the assumption that the number of members to spread the cost increased by that value. After further analysis, if the member amount decreased in total member count, the number of individuals utilizing these devices would also decrease.

As the exact decrease in utilization and member values is unknown unless payer claims data is available, this analysis calculated the potential cost difference if the delta in the payer population was to be applied to the PMPM.

For example, Kentucky was found to have the most significant variance in nongroup and employer-covered lives population at 11.6% less than Minnesota's. The average variance across all states was 4% less of the population holding nongroup or employer insurance than M.N., calculating a less than one cent increase in PMPM. As the specific utilization rate cannot be assumed without payer claims data, and the average impact would increase at less than one cent PMPM, this calculation was not included in the fiscal estimate methodology.

Similar outcomes were calculated when comparing the difference in disability prevalence in each state and subsequent impact in PMPM. The average variance across all states was found to have a 1.9% higher disability prevalence when compared to M.N. This difference would equate to less than one cent increase in PMPM. Additionally, the disability rate referenced by the US Census Bureau is not exclusive to prosthetic and orthotic device utilization pathologies and is subsequently a gross overestimate based on the inclusion of non-mobility-affecting categories (deaf, blind). For these reasons, this calculation was not included in the methodology.

This study also analyzed Medicaid's Durable Medical Equipment Prosthetic Orthotic Schedule (DMEPOS) reimbursement state rate

differences between the two most frequently coded prosthetic L-codes (L5301 and L5321) and L1970, one of the most coded orthotic L-codes [19].

Only Idaho and Oregon were found to have higher reimbursement rates across all three codes, at 2.19%. This would equate to a minute impact at less than a one-cent increase in PMPM.

All the estimates found within the results sections are calculations that estimate the potential per month per member cost per state, based on the assumptions above. The basis of these calculations originated with the actuarial study by Minnesota's Commerce Department. All assumptions and calculations completed in this research are not made on an actuarial basis. The calculations are based on population assumptions made available through the U.S. Census Bureau and supporting publicly available data, as referenced.

Image 1: The calculations within images 1 - 4 stem from Minnesota's \$0.39 PMPM estimate, referenced within Minnesota Commerce Department's analysis [14]

| | Totals | Orthotics | Prosthetics |
|--|------------------|---------------|--------------|
| Paid expenditures: | \$116,395,832.00 | 44.74% | 55.26% |
| Device breakdown | 106,296 | 84,776 | 21,520 |
| PMPM | \$0.39 | \$0.175 | \$0.2158 |
| Per device cost (PMPM divided by # of devices) | NA | \$0.000002060 | \$0.00001000 |

Image 2:

| Equation assumptions: | Column I * \$0.00001 | 50% of column G based on assumption: patients will receive an activity specific and general use device at 50% of the cost (per 2024 NJ Fiscal Analysis) | MN Commerce Department 2024 analysis quotes 0.37 of the population | MN Commerce Department 2024 analysis quotes 1.47% of the population. | Column J * \$0.00000206 | Columns G+H+K = Total State PMPM for O&P rec & fairness - exception of TN px only | Columns H+K = Total State PMPM for O&P rec & fairness - exception of TN px only |
|-----------------------|-----------------------------|--|--|--|----------------------------|---|---|
| State | Prosthetic general use cost | Prosthetic active use cost | Estimated annual prosthetic device utilization | Estimated annual orthotic device utilization | Orthotic cost | General-use & Activity-specific PMPM | Activity-specific only PMPM |
| Idaho | \$0.06 | \$0.03 | 5955 | 23658 | \$0.05 | \$0.14 | NA |
| Kentucky | \$0.14 | \$0.07 | 13757 | 54657 | \$0.11 | \$0.32 | NA |
| Maryland | \$0.19 | \$0.09 | 18954 | 75306 | \$0.16 | NA | \$0.25 |
| Massachusetts | \$0.21 | \$0.11 | 21157 | 84058 | \$0.17 | NA | \$0.28 |
| New Hampshire | \$0.04 | \$0.02 | 4120 | 16367 | \$0.03 | NA | \$0.05 |
| New Jersey | \$0.28 | \$0.14 | 28306 | 112457 | \$0.23 | NA | \$0.37 |
| Ohio | \$0.35 | \$0.18 | 35494 | 141016 | \$0.29 | \$0.82 | NA |
| Oregon | \$0.13 | \$0.06 | 12676 | 50363 | \$0.10 | NA | \$0.17 |
| Pennsylvania | \$0.39 | \$0.19 | 38589 | 153314 | \$0.32 | \$0.89 | NA |
| Tennessee | \$0.22 | \$0.11 | 21576 | 85722 | \$0.18 | \$0.50 | NA |

Image 3:

| <i>Equation assumptions:</i> | <i>Insurance coverage of the total state population per 2022 Kaiser Family Foundation</i> | <i>Under 65 yo population data from 2022 US Census Bureau</i> | <i>Disability rate under 65 yo per 2022 US Census Bureau</i> |
|------------------------------|---|---|--|
| State | Non-group & employer insured difference from MN | Delta from MN's under 65 yo population | Delta from MN's under 65 yo population |
| Idaho | -6.30% | 0.0% | 2.0% |
| Kentucky | -11.60% | 0.0% | 5.6% |
| Maryland | -1.80% | 0.0% | 0.10% |
| Massachusetts | -1.10% | -1.0% | 0.3% |
| New Hampshire | 1.30% | -3.0% | 1.3% |
| New Jersey | -0.90% | 0.0% | 1.0% |
| Ohio | -9.70% | -1.0% | 2.4% |
| Oregon | -7.40% | -2.0% | 2.6% |
| Pennsylvania | -5.10% | -3.0% | 2.3% |
| Tennessee | -6.30% | 0.0% | 3.4% |

Image 4:

| <i>Equation assumptions:</i> | <i>US Census info; row 13 from cost analysis projections</i> | <i>Annual saving, per state on the assumption individuals provided accurate care savings 115k over the average US lifespan (76.1 yrs)</i> | <i>Per Kaiser Foundation; row 6 from cost analysis projections</i> | <i>Annual state cost</i> | <i>Net State cost/savings per year</i> |
|------------------------------|--|---|--|------------------------------|--|
| State | Total O&P population under 65 | O&P population (115,000)/ 76.1 | Total commercial & non-group members | (PMPM *12) member population | Annual cost - Annual savings |
| Idaho | 29613 | \$44,750,119 | 796652 | \$1,319,803 | \$43,430,316 |
| Kentucky | 68414 | \$103,384,896 | 1840481 | \$7,044,250 | \$96,340,646 |
| Maryland | 94260 | \$142,443,003 | 3037840 | \$9,109,946 | \$133,333,057 |
| Massachusetts | 105216 | \$158,998,548 | 3430942 | \$11,484,614 | \$147,513,934 |
| Minnesota | 142092 | \$214,725,174 | 2885383 | \$22,936,798 | \$191,788,375 |
| New Hampshire | 20486 | \$30,958,498 | 694758 | \$452,818 | \$30,505,680 |
| New Jersey | 140763 | \$212,716,753 | 4605398 | \$20,624,277 | \$192,092,476 |
| Ohio | 176510 | \$266,736,759 | 4930773 | \$48,690,503 | \$218,046,256 |
| Oregon | 63039 | \$95,262,570 | 1839778 | \$3,689,756 | \$91,572,814 |
| Pennsylvania | 191903 | \$289,997,494 | 5840517 | \$62,703,522 | \$227,293,972 |
| Tennessee | 107299 | \$162,146,689 | 3195639 | \$19,182,807 | \$142,963,882 |

Results

States with prior enacted legislation covering insurance fairness and pursuing 2024 legislation covering prosthetic and orthotic devices for both activity-specific insurance coverage only:

- Maryland (SB0614/HB0865): \$0.01 - \$0.25 PMPM
- Massachusetts (bill number H4096): \$0.01 - \$0.28 PMPM
- New Hampshire (bill number SB 177): \$0.01 - \$0.05 PMPM
- New Jersey (bill number not yet assigned): \$0.01 - \$0.37 PMPM
- Oregon (bill number not yet assigned): \$0.01 - \$0.17 PMPM

States pursuing 2024 legislation covering prosthetic and orthotic devices for both activity-specific and general use (fairness) insurance coverage:

- Idaho (bill number not yet assigned): \$0.01 - \$0.14 PMPM
- Kentucky (bill number not yet assigned): \$0.01 - \$0.32 PMPM
- Minnesota (bill numbers HF 3339/SF3351): \$0.01 - \$0.39 PMPM
- Ohio (bill number not yet assigned): \$0.01 - \$0.82 PMPM
- Pennsylvania (bill number not yet assigned): \$0.01 - \$0.89 PMPM
- Tennessee (bill number not yet assigned): \$0.01 - \$0.50 PMPM

Discussion

This analysis conservatively estimates PMPM increases concerning each state's proposed legislation based on the following assumptions:

- The PMPM identified in Minnesota's Commerce Department 2024 analysis can be applied to state specific populations to estimate a PMPM. Further analysis against state specific all payer claims data is needed as utilization is likely varied due to disability prevalence differentials.
- Minnesota's cost estimate does not account for the potential healthcare savings associated with publicized improved health outcomes as seen in image 4. Recent literature cites sizable healthcare savings (\$115,000 per patient) when providing device access within their treatment plan. Thus, each state would reap a net benefit annually. Each state's increased PMPM cost was included in this calculation [13].

The above net benefit assumes every individual receiving a prosthetic or orthotic device would see subsequent improvements in quality of life and health. This calculation was not included in the PMPM cost analysis methodology but instead considered in terms of potential annual savings per this policy review of relevant industry findings.

Additional fiscal impact considerations include relevant legislation proposed in the 11 states would total a small proportion of the total healthcare cost, and the probable net positive fiscal benefit based on previous studies would be advantageous to all patients and healthcare systems alike. Minnesota's analysis quotes coverage of these devices as providing optimal health outcomes for this population and

minimizes associated impacts on health disparities. In conclusion, the increase in PMPM is less than the estimated annual healthcare savings calculated per state. This study

anticipates the 11 states would benefit from healthcare savings and patient outcome perspective if the relevant legislation is to be enacted. Additional research is needed to confirm long-term fiscal and social impact.

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